FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0680

January 26, 2010

David Rowe
Madison Memorial Hospital
P.O. Box 310
Rexburg, ID 83440

RE: Madison Memorial Hospital, provider #130025

Dear Mr. Rowe:

Based on the Medicare/Licensure survey completed at Madison Memorial Hospital on January 12, 2010 by our staff, we have determined that Madison Memorial Hospital is out of compliance with the Medicare Hospital Conditions of Participation on Patient Rights (42 CFR 482.13). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this condition to be unmet substantially limit the capacity of Madison Memorial Hospital to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **February 26, 2010. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than February 18, 2010.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures
ec: Kate Mitchell, CMS Region X Office

MADISON
MEMORIAL HOSPITAL

Terry Conrad, Chief Quality Officer

450 E. Main, PO Box 310 • Rexburg, ID 83440-0310 • (208) 359-9801 • FAX 359-6415 • tconrad@mmhnet.org

February 16, 2010

Bureau of Facility Standards
Gary Guiles, RN, Health Facilities Surveyor
3232 Elder St.
P. O. Box 83720
Boise, ID 83720-0036

Re: State Deficiency

Dear Mr. Guiles,

On January 15, 2010 we received the deficiency report from the audit which concluded on January 6th. Enclosed is our response to the recent Statement of Deficiency/Plan of Correction. We want to thank-you for the opportunity to improve our processes in the delivery of patient care.

If you have any question please contact me at 208-359-9801.

Respectfully,

Terry Conrad

Terry Conrad, RN, BSN
Chief Quality Officer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130025	A. BUILDING _____ B. WING _____	01/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON MEMORIAL HOSPITAL	450 EAST MAIN STREET REXBURG, ID 83440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your hospital. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Teresa Hamblin, RN, HFS Susan Costa, RN, HFS Acronyms used in this report include: AMU = Ambulatory Medical Unit ASU = Ambulatory Surgical Unit bpm = Beats per Minute CM = Case Manager CMS = Centers for Medicare and Medicaid Services CRNA = Certified Registered Nurse Anesthetist CS = Central Sterilization DVT = Deep Venous Thrombosis ED = Emergency Department H&P = History and Physical ICU = Intensive Care Unit IM = Intramuscular ID = Identification IV = Intravenous MD = Medical Doctor mg = milligram ml = milliliter MLA = a type of pipette, no definition found MRI = Magnetic Resonance Imaging MSW = Medical Social Worker NICU =Newborn Intensive Care Unit NM = Nurse Manager OB = Obstetric Department PACU = Post Anesthesia Care Unit PCP = Primary Care Physician PDR = Physician Desk Reference	A 000	RECEIVED FEB 17 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Performance Improvement Director 2/16/10

An[illegible]ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that oth[illegible]feguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days foll[illegible]g the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 PI = Performance Improvement PICC = Peripherally Inserted Central Catheter POC = Plan of Care PP =Post Partum Department prn = As Needed pt = Patient RN =Registered Nurse ul = microliter x = Times	A 000		
A 046	482.12(a)(2) MEDICAL STAFF - APPOINTMENTS [The governing body must] appoint members of the medical staff after considering the recommendations of the existing members of the medical staff. This STANDARD is not met as evidenced by: Based on staff interview and review of credentials files, the hospital failed to ensure 4 of 7 practitioners (B, C, D, and E) had been appointed to the medical staff and granted specific privileges defining their practice. The hospital also failed to implement a consistent process to request and grant privileges. This resulted the inability of the hospital to define what procedures practitioners could perform. Findings include: 1. Practitioner B was an orthopedic surgeon. He currently practiced at the hospital. A 6 page untitled form in his credentials file listed various diseases and medical procedures. It was dated 7/31/1986. Each disease or procedure contained 3 columns labeled "Requested, Recommended," and "Not Recommended." Certain diseases and procedures were marked with an X indicating what conditions the physician requested to be allowed to treat. None of the boxes, indicating whether these requests were recommended or	A 046	Effective 2/12/10every credentialing file at Madison Memorial Hospital has been reviewed. Any file in which there is not a clear delineation of privileges for the practitioner is being re-done. Delineation of privileges have been approved for practitioner B, C, D, and E.	

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A 046	Continued From page 2 not recommended, were checked. A form, titled "Recredentialling Checklist," contained information such as how many procedures the physician had performed and current licenses held by the physician. It was signed by the Chief of the Medical Staff and the Chairman of the Board of Trustees in April 2009. Neither the Recredentialling Checklist nor other forms in Practitioner B's file stated what specific privileges the hospital was granting to him. The Chief Quality Officer, who was responsible for maintaining physician credentials files, was interviewed on 1/05/10 at 2:00 PM. She confirmed the documentation in the credentials file. She also stated no documentation was present showing Practitioner B's specific privileges had been reviewed since 1986. 2. Practitioner C was a family practice physician. He was reappointed to the medical staff in June 2009 and currently practiced at the hospital. A 6 page untitled form in his credentials file listed various diseases and medical procedures. The form stated "Please check the privileges and categories for what you are applying." Checks were made next to various diseases and procedures. The form was signed by the physician on 3/22/1998. No documentation was present indicating what specific privileges the hospital had granted to him. The Chief Quality Officer was interviewed on 1/05/10 at 2:00 PM. She confirmed the credentials file did not include what specific privileges Practitioner C had been granted. She said Physician C had core privileges* but stated these were not documented.	A 046	Attached here to as exhibit 1 are copies of privilege request forms which are now used for every initial and re-credentialing appointment at Madison Memorial Hospital.	

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A 046	Continued From page 3 3. Practitioner D was a CRNA. He currently practiced at the hospital. A 2 page form, titled "Privilege Request for Anesthesiology," was present in his credentials file. It stated he was applying for "CORE PRIVILEGES," which "...include the ability to provide medical management of patients who are rendered unconscious or insensible to pain and emotional stress during surgical, obstetrical, and certain other medical or dental procedures." The form was signed by the Chairman of the Board of Trustees on 3/12/08. The form did not include privileges for specific procedures the CRNA performed, such as regional blocks and epidural anesthesia. The form also did not indicate specific privileges had been granted to the practitioner. The Chief Quality Officer was interviewed on 1/05/10 at 2:00 PM. She confirmed the credentials file did not include what specific privileges Practitioner D had been granted. 4. Practitioner E was an obstetrician. He currently practiced at the hospital. A 4 page form, titled "DIVISION OF OB/GYN," was present in his credentials file. "CATEGORY III" was checked on the form. It stated "Obstetric examples" such as vaginal deliveries and cesarean deliveries and "Gynecologic examples" such as "All gynecologic illnesses and complications" and "All gynecologic procedures except [4 listed procedures]." The form was signed by the physician on 2/25/1990. No other signatures were on the form. A "Recredentialling Checklist" was signed by the Chairman of the Board of Trustees on 6/26/09. The form did not contain any information regarding what privileges were granted to Practitioner E.	A 046	Attached here as exhibit 2 is the revised privilege request completed for practitioner "B". This privilege request will be used for all future orthopedic surgeon appointments or re-appointments. Attached here as exhibit 3 is the revised privilege request completed for practitioner "C". This privilege request will be used for all future family practice appointments or re-appointments. Attached here as exhibit 5 is the revised privilege request completed for practitioner "D". This privilege request will be used for all future CRNA appointments or re-appointments. Attached here as exhibit 6 is the revised privilege request completed for practitioner "E". This privilege request will be used for all future OB/GYN appointments or re-appointments.	

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A 046	Continued From page 4 The Chief Quality Officer was interviewed on 1/05/10 at 2:00 PM. She confirmed the credentials file did not include what specific privileges Practitioner E had been granted. 5. At least 4 different types of forms were used for privileges at the hospital. Practitioner B's credentials file contained a 6 page untitled form that listed various diseases and medical procedures. Each disease or procedure contained 3 columns labeled "Requested, Recommended," and "Not Recommended." Practitioner C's file contained a different 6 page form. Practitioner D's file contained a 2 page form for requesting core privileges. Practitioner E's file contained a 3 page form which listed 2 categories of practitioner and examples of procedures the practitioner might request. The "MADISON MEMORIAL HOSPITAL CREDENTIALING PROCEDURES AND POLICES OF MEDICAL STAFF," dated 2008, stated the hospital board would grant specific privileges but it did not provide a systematic procedure such as a consistent form for applicants to request specific privileges. This prevented the hospital from defining specific procedures practitioners could perform. The Chief Quality Officer was interviewed on 1/5/09 at 2:00 PM. She confirmed the privilege request forms were all different and a uniform approach to granting specific privileges had not been implemented. She also reviewed the credentials files and acknowledged it was difficult to tell which specific privileges had been granted to practitioners.	A 046	Admittedly over time Madison Memorial Hospital has used a variety of forms to qualify medical staff for privileges. However, currently only one form is in use. See attached exhibit 1.	

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A 046	Continued From page 5 The hospital failed to document what specific privileges had been granted to practitioners. * core privileges - a set of privileges that can be performed by any member of the medical staff or a specialty group of the medical staff, i.e. any orthopedic surgeon appointed to the medical staff would be allowed to cast a fractured limb and would not be granted a specific privilege to do so	A 046		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interviews and review of clinical records, hospital policies, and incident reports, it was determined the hospital failed to protect and promote patients' rights. This resulted in the inability of the hospital to respond in systematic ways to patients with grievances and restraints and to ensure safe and effective care was provided. Findings include: 1. The hospital failed to ensure the governing body accepted responsibility for the grievance process. Refer to A119 as it relates to the failure of the governing body to review and resolve grievances or delegate the responsibility in writing to a grievance committee and the failure of the governing body to establish an effective grievance process/policy. 2. The hospital failed to provide a written response to grievances. Refer to A123 as it relates the hospital's failure to provide complete written responses to grievances. 3. The hospital failed to ensure patients received	A 115	Attached here as exhibit 7 is the new grievance policy for Madison Memorial Hospital. A grievance committee has been formed.	

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A 115	Continued From page 6 care in a safe setting. Refer to A144 as it relates to the lack of a safe environment for patients. 4. The hospital failed to ensure patients' POCs were modified to address the use of restraints. Refer to A166 as it relates to incomplete care plans for patients who were restrained. 5. The hospital failed to ensure orders for restraints were not written as PRN orders. Refer to A169 as it relates to the lack of definitive restraint orders. 6. The hospital failed to ensure training requirements for physicians were specified in hospital policy. Refer to A176 as it relates the hospital's failure to ensure a process was in place to validate that physicians and other licensed independent practitioners had a working knowledge of the hospital's policy regarding the use of restraints. 7. The hospital failed to ensure patients, who had restraints applied for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person. Refer to A178 as it relates to the evaluations for patients who were restrained. The cumulative effect of these systemic practices prevented the hospital from investigating complaints, compromised the hospital's ability to keep patients safe, and prevented staff from utilizing restraints in a consistent manner.	A 115	Attached here as exhibit 9 is a copy of the recently enacted policy on restraints. At the in-service on 2/17/10 particular emphasis was given to the special requirements and limitation imposed when restraints are used to manage violent or self destructive behavior. Attached here to as exhibit 10 is the outline for the in-service.	
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform	A 119		

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A 119	Continued From page 7 each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies and grievance-related documents, it was determined the hospital's governing body failed to review and resolve grievances or delegate the responsibility in writing to a grievance committee. This directly affected 12 of 12 patients (#46, #47, #48, #49, #50, #51, #52, #53, #54, #60, #61, and #62) whose grievances were reviewed. The hospital's governing body also failed to establish a grievance process/policy that ensured the hospital responded to all grievances in an appropriate manner. These failures resulted in an ineffective, inefficient, and inconsistent grievance process. Findings include: 1. The hospital's grievance policy, "Patient Concerns," dated 7/03/09, was approved by the Chief Executive Officer. The following problems were identified with the policy: a. The policy failed to identify the role of the governing body in reviewing or resolving grievances. b. The policy failed to reference the governing body's delegation of review and resolution of grievances to a grievance committee. It failed to reference the existence of a grievance committee. c. The definition of grievances described in the	A 119	Attached as exhibit 9 is a copy of Madison Memorial Hospital's recently revised restraint policy. This policy was approved 2/22/2010. All patient care staff have been educated on this policy and their responsibilities in this regard and a video and test has been set-up on our education computer system, which will be required for clinical and housekeeping employees to have done by 2/26/2010. Particular attention was made to the necessity of updating the plan of care of any patient in restraints.	

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A 119	Continued From page 8 policy was inconsistent with the CMS definition of grievances. As a result, the policy/process did not trigger responsiveness to all grievances. The policy explained that a grievance existed whenever a patient complained of a situation involving an inappropriate action by a hospital employee, medical staff member or contract service personnel that could harm that patient or another patient in similar circumstances. This suggested overtly inappropriate action on the part of a hospital employee. It did not include in its definition, as described in CMS interpretive guidelines at CFR482.12(a)(2), that a grievance also included complaints by the patient or patient's representative (not resolved at the time of the complaint by staff present) regarding the patient's care, abuse or neglect, or issues related to the hospital's compliance with the CMS Hospital Conditions of Participation or a Medicare beneficiary billing complaint related to patient rights and limitations. d. The hospital policy differentiated grievances from concerns and did not treat concerns as grievances. A concern was described as a written or verbal complaint expressed by the patient to a hospital employee during or after the patient's services were provided. Since not all written complaints were considered by the hospital's policy to be grievances, the process did not require the same level of responsiveness to "concerns." e. The policy failed to specifically require written responses to all grievances as required by regulation. Instead the policy allowed for either a written or verbal response to grievances. It stated "the patient will be provided with a written or verbal response within seven days of resolution."	A 119		

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A 119	Continued From page 9 During an interview on 1/07/10 between 11:10 AM and 12:30 PM, the Chief Quality Officer acknowledged the grievance policy needed updating and that she would do so right away. 2. During an interview on 1/07/10 at 9:20 AM, the Chief Quality Officer explained that the hospital had an informal grievance committee that met irregularly. She stated that since the committee was informal, they did not keep meeting minutes. She further stated the informal committee was typically attended by herself, the Chief Nursing Officer, the Chief Financial Officer, the Performance Improvement Manager, and Social Workers. She stated she did not have any documentation of the information discussed during the meetings for surveyor review. 3. During an interview on 1/07/10 at 12:30 PM, the Performance Improvement Manager stated that specific complaints/grievances were not discussed with the governing body unless a sentinel event had occurred, He stated he provided the Board with a summary of complaint trends annually; the last report was December 2009. He stated the Board was not involved with details of complaints. They were generally only involved with trends. He stated he was not aware of anything in writing showing delegation of grievances to a grievance committee. 4. Refer to A123 as it relates to the failure of the governing body to ensure complainants received appropriate written responses to grievances involving the following patients: #46, #47, #48, #49, #50, #51, #52, #53, #54, #60, #61, and #62. The hospital's governing body failed to ensure the	A 119		

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A 119	Continued From page 10 grievance process operated effectively.	A 119		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies, grievance-related documents, and incident reports, it was determined the hospital either failed to provide written responses or provided incomplete written responses to 12 of 12 patients (#46, #47, #48, #49, #50, #51, #52, #53, #54, #60, #61, and #62) and/or patient representatives whose grievances were reviewed. This resulted in a lack of clarity about whether the grievances had been thoroughly investigated and resolved. It had the potential to interfere with patient understanding and satisfaction. Findings include: Surveyors initially requested to view the grievance log for the last quarter of 2009 (October through December). Instead of being given the grievance log, the Chief Quality Office provided surveyors with the hand written and verbal recall of "Patient Concerns and Complaints" for the same time period. During an interview on 1/07/10 at 11:30 AM, the Chief Quality Officer explained that the hospital did not keep a grievance log or have dedicated files or forms for grievances. She further explained that instead of writing letters, the	A 123	Attached as exhibit 9 is a copy of Madison Memorial Hospital's recently revised restraint policy. This policy was approved 2/22/2010. All patient care staff have been educated on this policy and their responsibilities in this regard and a video and test has been set-up on our education computer system, which will be required for clinical and housekeeping employees to have done by 2/26/2010. Particular attention was made to the necessity of updating the plan of care of any patient in restraints.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	Continued From page 11 grievances were often handled with phone calls and that the steps taken to resolve the grievances were not consistently documented. The following are examples of grievances submitted by patients or patient representatives. In each of these examples, either the hospital failed to respond to the grievances in writing or failed to include all pertinent information, such as the steps taken to investigate the grievance or the resolution of the grievance or the date of completion, in the written responses. 1. Patient #46 was a 21 year-old male who had presented to the ED on 5/09/09 for abdominal pain. He was evaluated, sent home, and returned to the ED later the same day. After the second visit to the ED, he was admitted to the hospital at which time a surgical consultation was obtained. Patient #46 died after admission as a result of an abdominal aortic aneurysm (the exact date of death was unknown). In an interview on 1/07/10, at 11:30 AM, the Chief Quality Officer stated a complaint had been brought to the attention of the Chief Executive Officer on 5/26/09 by an outside entity who had received a complaint from Patient #46's father. The Chief Quality Officer explained she had met with the family on 2 occasions and informed them the case would be sent for peer review. She confirmed all interactions with Patient #46's family had been verbal and no written follow up was provided to the family. 2. Patient #51 was a 22 year-old female who presented to the ED on 10/06/09 with complaints of severe abdominal pain. According to the Chief Quality Officer during an interview on 1/07/10 at	A 123		

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A 123	Continued From page 12 12:00 PM, she met with Patient #51 and family members who voiced concerns regarding the medical treatment she received in the ED. Patient #51 claimed she miscarried 2 days after her ED visit as a result of treatment received in the ED. The Chief Quality Officer explained to surveyors that her investigation included reviewing the medical record, speaking with the physician and nurse who provided care in the ED, and, and consulting with the hospital pharmacist regarding medications prescribed to treat Patient #51. After investigating, she called Patient #51 who accused the hospital of negligence. The Chief Quality Officer stated the hospital had no additional contact with Patient #51 after the phone call. She did not recall the date the phone call was made to Patient #51. She confirmed no follow-up letter was sent. 3. Patient #47 was a 19 year-old male, admitted on 10/17/09 with multiple fractures of the mandible (jaw). A letter, dated 11/12/09, from Patient #47's family described dissatisfaction with the care provided by nursing, medical, and surgical staff. In an interview with the Chief Quality Officer on 1/07/10 at 11:40 AM, she stated she had sent a letter to the family on 11/30/09 with an adjustment in the billing charges to the patient. The letter failed to state what steps were taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. The letter did include information regarding the hospital's intention to make adjustments to Patient #47's bill. The Chief Quality Officer confirmed that the letter to the family was an acknowledgement letter and did not include all of the steps identified above.	A 123		

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A 123	Continued From page 13 4. Patient #52 was a 62 year-old male admitted to the hospital on 7/07/09 for a total hip replacement. He was discharged on 7/12/09. Patient #52's wife sent a letter, dated 8/05/09, addressed to the Chief Nursing Officer. The letter listed her concerns about safety issues, care issues, and surgical mistakes that occurred during her husband's hospitalization. In an interview on 1/07/10 at 12:15 PM, the Chief Quality Officer stated she did not become aware of the letter until 11/05/09. She forwarded the complaint to the Chief Nursing Officer and to the Performance Improvement Manager. The Chief Quality Officer explained she had contacted Patient #52's wife on 11/11/09 (4 months after the date of the complainant's letter) by telephone and informed her that the account would be re-billed with adjustments made. She further stated she did not know what steps were taken by the other departments in the resolution of this matter. She confirmed she did not write a letter of response regarding the grievance investigation to the family. 5. Patient #48 was a 13 year-old female who was treated in the ED on 8/22/09 for a laceration and was subsequently sent home. In an interview on 1/07/10 at 11:45 AM, the Chief Quality Officer stated Patient #48's mother contacted her by telephone on 12/02/09 to share her concerns about the care provided to her daughter in the ED. The Chief Quality Officer stated she offered Patient #48's mother a billing adjustment but did not send a written response to the complainant. 6. Patient #49 was a 34 year-old female who was evaluated in the ED on 11/03/09. During an	A 123		

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A 123	Continued From page 14 interview on 1/07/10 at 11:50 AM, the Chief Quality Officer stated she received a complaint from Patient #49 on 11/04/09 by telephone. The complaint involved concerns about a physician's attitude and manner. A letter of response to Patient #49, dated 11/25/09, did not include the results of the grievance process or the date of completion. The letter expressed the staff's intention to address the issue with the physicians but did not state the steps had been initiated and/or completed. The letter stated an adjustment had been made to Patient #49's bill. The Chief Quality Officer stated she felt the letter provided resolution of the matter. 7. According to an ED History and Physical report, dated 11/08/09, Patient #50 was a 25 year-old female, seen in the ED on 11/08/09 for a complaint of fever, chills, and muscle aches. She had delivered a baby less than 1 week prior to her ED visit. She was told she had a virus, and was sent home. According to an interview on 1/07/10 at 11:55 AM with the Chief Quality Officer, Patient #50's husband called on 11/19/09 with concerns about the medical treatment provided to his wife in the ED on 11/08/09. He also stated that his wife was seen the following week by her physician, who diagnosed her symptoms as Mastitis, (an infection of the milk ducts in the breasts) and was then started on antibiotic therapy. The Chief Quality Officer explained she subsequently reviewed Patient #50's medical record, interviewed the involved ED physician, and followed up by calling Patient #50 by telephone to offer an adjustment on the bill. She did not know	A 123		

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A 123	Continued From page 15 the date of the follow-up phone call and stated she did not write it down. She confirmed no follow-up letter was sent, although she felt there was resolution in the matter. 8. Patient #53 was a 25 year-old male with multiple ED admissions over the previous year. His most recent admission to the ED was on 5/28/09. According to an interview with the Chief Quality Officer on 1/07/10 at 12:20 PM, she and the Chief Executive Officer met with Patient #53 and his grandmother on 6/26/09 to discuss concerns regarding treatment received by the hospital. Patient #53 alleged he had been denied medical treatment and a surgical procedure because he did not have medical insurance. He requested the medical bill be written off. In an interview on 1/07/10 at 12:20 PM with the Chief Quality Officer, she stated after meeting with Patient #53 to discuss his complaint, she followed up with an investigation. She explained, after completing her investigation, she tried to contact Patient #53 by telephone but his cell phone had been disconnected. She stated she did not mail a letter to Patient #53 because he had moved out of state and she did not know his new address. 9. Patient #54 was a 28 year-old male who had been to the ED on 5/07/09, and then sent home. He returned to the ED on 5/14/09 with a continuation of symptoms, at which time he had a computed tomography (CT) scan. He was subsequently taken to surgery for a ruptured appendix. According to an interview on 1/07/10 at 12:20 PM with the Chief Compliance Officer, she met with	A 123		

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A 123	Continued From page 16 Patient #54's wife on 5/14/09 who expressed concerns regarding the quality of care her husband received in the ED. The Chief Quality Officer stated she had asked Patient #54's wife to write down her concerns and send her a letter. She also stated there were multiple telephone calls exchanged between herself and Patient #54's wife who reportedly wanted to negotiate a reduction in her husband's bill. The hospital made an offer but Patient #54's wife reportedly did not want to accept the hospital's offer and threatened to contact an attorney. The Chief Quality Officer stated at that point communication between hospital staff and the complainant stopped. She confirmed there was no written letter sent to the complainant. 10. Patient #60 was a 94 year-old male, admitted on 10/09/09 and discharged on 10/20/09. The following information was provided by the Chief Quality Officer on 1/07/10 at 12:00 PM in a written summary format. There was no follow-up interview conducted regarding the information provided. According to the information provided, a letter, dated 10/29/09, was sent from Patient #60 to the Chief Executive Officer listing concerns regarding quality of nursing care received during his stay. The letter was filed as a Patient Complaint and forwarded to the Performance Improvement Manager, who forwarded it to the Chief Nursing Officer. An acknowledgement letter, dated 12/07/09, was sent to Patient #60, assuring him his concerns would be addressed. There was no documentation indicating the hospital provided Patient #60 with a follow-up letter that described the actual steps taken to investigate the grievance and the date of completion.	A 123		

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A 123	Continued From page 17 11. Patient #61 was a 61 year-old male, admitted to the hospital on 11/27/09. The following information was provided by the Chief Quality Officer on 1/07/10 at 12:00 PM in a written summary format. According to the summary information, Patient #61 was a family member of an employee of the hospital. The employee filed an incident report on behalf of Patient #61; claiming discharge planning was not appropriate. The incident report was labeled as a grievance, and a "Root Cause Analysis" was initiated. Documentation indicated the Chief Quality Officer had spoken with the complainant on 12/29/09 regarding the complaint. There was no evidence written follow-up was provided to the complainant. 12. Patent #62 was a 21 year-old female, who was admitted as an OB patient on 11/27/09. The following information was provided by the Chief Quality Officer on 1/07/10 at 12:00 PM in a written summary format. According to the summary, Patient #62 sent an undated letter addressed to the Performance Improvement Manager with details of complications during her hospitalization. The letter was forwarded to the Chief Quality Officer on 12/09/09, and then listed as resolved on 12/31/09. There was no documentation to indicate the hospital sent a written response to Patient #62.	A 123		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and incident reports, the hospital failed to ensure a safe environment of care was provided	A 144		

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A 144	Continued From page 18 to 3 of 50 patients (#3a, #57 and #58) whose medical records were reviewed. This resulted in injury to Patient #57 and the potential for injury to other patients. Findings include: 1. Patient #57's medical record documented an 85 year-old male who presented to the ED on 11/27/09 at 11:23 AM. The ED physician conducted the H&P and admitted Patient #57 to the hospital under the care of his PCP. The ED physician's "Clinical Report," dated 11/27/09, stated Patient #57's diagnoses included changed mental status, dementia, and rule out cerebrovascular accident. Patient #57 was admitted to the medical floor. He was taken to radiology for an MRI. A nursing note, dated 11/27/09 at 5:00 PM, stated "Nurse was called by MRI tech and told that pt was combative and aggressive and nurse needed to take him back to room and calm him. Arrived downstairs and found pt to be agitated and threatening. Pt had scissors in hand and all attempts to calm him were not effective. Doctor [name] was called for 1 to 1 order as well as Haldol to calm the pt. Police were called by House Supervisor and pt hit officer on left ear. Pt taken to floor by officer, pt hit head on way down, creating a 1 inch laceration on the right forehead. Laceration cleaned with soap and water and dressed with bandage. 5 mg Haldol given IM by House Supervisor." A verbal order by the PCP for "2. Haldol 5 mg IV now. 3. Haldol 5 mg [by mouth every evening]. 4. Haldol 2.5 mg [by mouth every morning]" was documented on 11/27/09.at 5:15 PM. The order was not signed by the ordering physician until 12/18/09.	A 144	On 2/17/10 hospitals staff were trained on restraints. Specific attention was on chemical restraints. Attached here as exhibit 10 is an outline of that in-service. Attached as exhibit 9 is a copy of Madison Memorial Hospital's recently revised restraint policy. This policy was approved 2/22/2010. All patient care staff have been educated on this policy and their responsibilities in this regard by 2/25/10. All nursing staff have been in-serviced regarding the use of drugs as a form of restraint. The recently enacted restraint policy has been attached as exhibit 9, which clearly identifies staff responsibilities in this regard. A video and test has been set-up on our education computer system, HealthStream, which will be required for clinical and housekeeping employees to be done by 2/26/2010. Starting on 2/9/2010 new employees are being introduced to the restraint policies and procedures in New Employee and New Nurse Orientation. Attached hereto as exhibit 14 are copies of the orders written for both Zyprexa (0430) and Valium (0515). These orders were in the patient's medical record on the date the surveyors were here. The patient had been discharged and her complete medical record was not on the unit, but in the medical records department when we received the call asking us to find them. We apologize that hospital staff did not retrieve the record from the medical records department.	

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A 144	Continued From page 19 A form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form," dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. The order did not include the dosages of the Haldol and Ativan or the times it could be given. It was signed by the PCP but not dated or timed. No documentation was present in the medical record that Patient #57 was evaluated by a physician after the incident, to determine why the patient was so agitated and combative. No documentation was present in the medical record that Patient #57 was evaluated to determine the extent of his injuries following the incident. The PCP's first progress note, dated 11/28/09 but not timed, stated "Fell last night & sustained [laceration] to head + chest contusion." An order, dated 11/28/09 but not timed, stated "Haldol 10 mg IM every 4 [hours as needed] Ativan 1 mg IM every 4 [hours as needed]." A physician progress note, dated 11/28/09 at 4:25 PM, stated "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." The form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form", dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. The order did not include the dosages of the Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at 8:10 AM, 12:00	A 144		

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A 144	Continued From page 20 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. A physician signed all 4 renewals but did not sign or date the first 2 signatures. The last 2 physician signatures had times next to the signatures but these appeared to have been written by the nurse. Patient #57 received the following medications: Haldol 5 mg IV at 5:48 PM on 11/27/09. Haldol 5 mg IM at 6:54 PM on 11/27/09. Haldol 10 mg IM at 5:14 AM on 11/28/09. Haldol 10 mg IM at 11:32 AM on 11/28/09. Haldol 30 mg was given by injection between 5:48 PM on 11/27/09 and 11:32 AM on 11/28/09. During this time, Patient #57 also received 7.5 mg of Haldol orally according tot he Medication Administration Summary. This was a very large dose according to the "PDR Drug Guide for Mental Health Professionals," Third Edition, copyright 2007, which stated "In general, older people take dosages of haloperidol in the lower ranges. Older adults may be more suscepible to tardive dyskinesia. Doses may range from 1-6 mg daily." While Patient #57 apparently did not suffer severe side effects from the medication, the dosages had the potential to negatively impact him. An incident report had been filled out describing events related to Patient #57's combativeness on 11/27/09. An entry on the incident report by the Safety Officer, dated 11/30/09 at 11:04 AM, stated "The patient became irritated and violent while in the radiology dept and thus this incident.	A 144	The pharmacy director sent out a memo on Haldol usage, indication, contraindications, side effects, responses to side effects, and appropriate dosage. Attached as exhibit 11 is a copy of that memorandum. Attached is exhibit 12 is a list of medications that we have identified as potentially being used as a restraint. We have built into our nurse charting a question that will pop-up asking if this drug is being used as a restraint to alert the nursing staff to verify what the drug will be used for.	

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A 144	Continued From page 21 The staff handled it appropriately, per protocol. In talking to the case managers and nursing staff, no staff members were harmed significantly." The entry did not comment on Patient #57's injuries or on the use of restraints. The Safety Officer was interviewed on 1/07/09 at 2:00 PM. She stated staff followed the the hospital protocol for violent patients by calling a "Code Armstrong" and then calling the police. She said staff did not want to irritate Patient #57 any more so they backed off and called police. She stated she thought the police had tasered the patient but she was not sure. She stated she did not review the case to identify other ways staff could have resolved the situation. She said she did not review the case for appropriate restraint usage. Patient #57's safety was compromised due to the ineffective response of staff to his combative behavior and the indiscriminate use of restraints. 2. Patient #3a was a newborn female born on 11/30/09. She was admitted directly to the NICU, and was discharged home at 18 days of age. Areas of concern were as follows: a. The infant had a security band placed after delivery, as there was a band number documented on the "Newborn Identification" sheet, undated. The document may also have been known as the "footprint" sheet. There was a set of footprints, and a print of "mother's" index finger. The sheet had the identification band number listed as 52753. The sheet contained areas for other details, such as birth date, time, sex of infant, weight, length, mother's hospital number. and infant's name. The areas were all left blank.	A 144	It is our protocol to document the baby's ID band # on the NICU Discharge Teaching Form, have the discharge nurse sign, and the mother or agent for the baby also sign this form. This was a case of the nurse charting that she did discharge teaching in her notes, but failed to fill out the Discharge Teaching Form appropriately per protocol. We addressed this problem in an e-mail to all NICU nurses upon receiving the findings from our Chief Nursing Officer. We addressed this issue in our NICU staff meeting on 1/27/2010. Training was done on the importance of and how to fill out this form in this meeting. It was also found that the Footprint sheet was not filled out and the security band # was transposed incorrectly on this sheet. We have revised the Newborn Identification Form, which was approved on January 21, 2010. See exhibit 13 for a copy of this form. We reduced the amount of information lines and consolidated the information with placing the mom and infant's admission sticker on the form along with a signature from the person taking the prints. We feel that the information now provided will meet the objectives of this form.	

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A 144	Continued From page 22 b. The "Special Care Nursery Teaching-Discharge" form, dated 12/18/09, had the mother's signature, but the area where the band number was to be written down was left blank, as was the area for the nurse signature, who was to verify the band and parent ID. c. The "Discharge Orders/Information Sheet" dated 12/18/__ (no year,) had only the mother's signature and not the discharging nurse signature. d. The "Newborn-Maternal Information" sheet documented the band number as 52735, as opposed to 52753 as noted above. e. The mother's record (Patient #3) on the form "Delivery Summary," had the band number documented as 52735. The policy "Identification of the Newborn," dated 12/22/09, stated identification bands would be attached to both mother and infant at birth. An additional matching band would be provided to the parent or support person. The nurse at the delivery would assume the responsibility to prepare and secure the bands in place on mother and infant. The number on the band was then recorded on the birth record. Each time the newborn would be taken to mother's room, mother would be requested to verify identification band data. The policy stated the band number was to be documented on the delivery record, Newborn ID form, and discharge forms. The policy further stated that the bands of parent and infant would be compared and verified at the time of the newborn's discharge. During an interview on 1/06/10 at 9:00AM with the	A 144		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 144	Continued From page 23 OB manager, she reviewed the record and confirmed the ID numbers were conflicting. She stated the nurse had not followed the newborn identification procedures as defined in the policy. 3. Patient #58 was a 49 year-old female admitted on 11/18/09 to ICU for hypoxia, altered mental status, and aspiration pneumonia. She was intubated and on a ventilator. Restraints were ordered to prevent her from dislodging her endotracheal tube. She was intubated on 11/19/09 at 7:00 PM and restraints were documented as being applied at that time. The first documented observation was at 11:00 PM. Patient #58 was intubated and restrained for 4 days (11/19/09 to 11/22/09.) There was documentation of the 30 minute checks through much of that duration, although there were 6 occasions when the patient checks were 1 hour or more. Patient #58 suffered a deep vein thrombosis in her left upper arm on 11/24/09. This was noted by nursing staff as a reddened area and ultrasound confirmed the DVT. Patient #58 was started on anticoagulant therapy and upon discharge to home continued treatment for this condition. In an interview with the Clinical Coordinator of the Medical Surgical and ICU on 1/07/10 at 4:10 PM, he reviewed the record and verified the lapses in documentation, as well as the initial delay of 4 hours before the initial 30 minute check. He offered no explanation for the delay. The Clinical Coordinator verified that Patient #58 suffered a deep vein thrombosis, and had had a PICC in place on that arm. He stated sometimes patients have complications associated with their hospitalization.	A 144		

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	130025	A. BUILDING _____ B. WING _____	01/12/2010

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A 144	Continued From page 24 The policy titled "Restraints-Physical Restraints," dated 12/29/09, stated that direct patient observation would be observed and documented every 30 minutes, and every 2 hours at which point the extremities would be released for range of motion, and to provide for skin care as well as for the assessment of circulation, sensation, and skin integrity. According to a National Institute of Health article, titled "Deep Venous Thrombosis and Pulmonary Embolism Following Physical Restraint," dated April, 2005; there is risk of deep vein thrombosis and pulmonary embolism associated with immobilization during physical restraint, despite no pre-existing risk factors.	A 144		
66	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure hospital staff incorporated restraint usage into each patient's plan of care for 2 of 5 medical patients (#56 and #57) reviewed who were physically and/or chemically restrained. This resulted in staff not knowing the process of a restraint assessment, intervention and evaluation of when a restraint should be used and or discontinued. It also had the potential to interfere with coordination of patient care. Findings include: 1. Patient #56's medical record documented an 84 year-old female who was admitted to the	A 166		

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A 166	Continued From page 25 hospital on 1/04/10 for pneumonia and had a history of dementia. Patient #56 was a current patient as of 1/07/10. Patient #56's medical record only contained two physician's progress notes. A physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was confused, agitated, and demanding to go home. A second physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was "more" agitated and uncooperative. He wrote that Patient #56 was now "throwing things." He noted that he was going to order Zyprexa. Zyprexa was an atypical antipsychotic, approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia and bipolar disorder. A pharmacy "Medications" audit sheet documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa Zydis 5 mg twice a day as needed. This order was discontinued on 1/06/10 at 2:49 PM. The pharmacy "Medications" audit sheet also documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa 5 mg intramuscular twice a day as needed. This order was discontinued on 1/06/10 at 2:50 PM. The original orders could not be found at the time of the survey. The Medical/ICU Manager, and the hospital's Clinical Educator reviewed the record on 1/07/10 at 2:30 PM, and also could not find the orders. On 1/06/10 at 2:45 PM, the physician ordered Zyprexa 5 to 10 mg by mouth three times a day as needed. This was documented on a physician's order sheet. On 1/06/10 at 2:55 PM, the physician ordered	A 166	Attached as exhibit 9 is a copy of Madison Memorial Hospital's recently revised restraint policy. This policy was approved 2/22/2010. All patient care staff have been educated on this policy and their responsibilities in this regard by 2/25/10. All nursing staff have been in-serviced regarding the use of drugs as a form of restraint. The recently enacted restraint policy has been attached as exhibit 9, which clearly identifies staff responsibilities in this regard. A video and test has been set-up on our education computer system, HealthStream, which will be required for clinical and housekeeping employees to be done by 2/26/2010. Starting on 2/9/2010 new employees are being introduced to the restraint policies and procedures in New Employee and New Nurse Orientation. Attached hereto as exhibit 14 are copies of the orders written for both Zyprexa (0430) and Valium (0515). These orders were in the patient's medical record on the date the surveyors were here. The patient had been discharged and her complete medical record was not on the unit, but in the medical records department when we received the call asking us to find them. We apologize that hospital staff did not retrieve the record from the medical records department.	

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A 166	Continued From page 26 Valium (a medication used for treating anxiety and insomnia) IV 5 mg three times a day PRN for anxiety. This was documented on a physician's order sheet. Nursing notes documented the following behaviors: A nursing note, dated 1/06/10 at 4:30 AM, stated Patient #56 had become belligerent. A nursing note, dated 1/06/10 at 4:45 AM, stated Patient #56 was refusing cares. A nursing note, dated 1/06/10 at 5:15 AM, stated Patient #56's physician was called to obtain IV medications because the patient was refusing to take meds by mouth or injection. Patient #56 was given Valium 10 mg on 1/06/10 at 5:38 AM according to the patient's Medication Administration Record. The original orders could not be found at the time of the survey. The Medical/ICU Manager, and the hospital's Clinical Educator reviewed the record on 1/07/10 at 2:30 PM, and also could not find the orders. A nursing note dated 1/06/10 at 12:00 PM, stated Patient #56 was agitated and confused. The nurse stated Patient #56 was wanting to go to bed even though she was in bed. Patient #56 was looking for people that were not there. The nurse stated that they walked Patient #56 around the halls at which time Patient #56 tried to get in other patients' rooms, became combative and hit the nurse. Patient #56 was given Zyprexa 5 mg on 1/06/10 at 12:09 PM according to the patient's Medication Administration Record. A nursing note dated 1/06/10 at 1:45 PM, stated	A 166		

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A 166	Continued From page 27 Patient #56 was very anxious, combative and un-cooperative. The nurse stated that they walked Patient #56 around the halls at which time Patient #56 was hitting and biting at the nurses. Patient #56 was given Zyprexa 5 mg on 1/06/10 at 2:48 PM (which Patient #56 then threw out), and then was given Valium 5 mg on 1/06/10 at 3:03 PM according to the patient's Medication Administration Record. The RN who worked with Patient #56 on 1/06/10 at 1:10 PM, was interviewed. The medication orders and nursing notes were reviewed. She stated that she did not know that using Zyprexa and Valium to control the patient's behaviors was considered a chemical restraint so she did not update Patient #56's Plan of Care to reflect the use of chemical restraints. This was confirmed through record review. 2. Patient #57's medical record documented an 85 year-old male who was admitted to the hospital on 11/27/09. The ED physician's "Clinical Report," dated 11/27/09, stated the patient's diagnoses included "Changed mental status. Dementia. Rule out cerebrovascular accident." A nursing note, dated 11/27/09 at 5:00 PM, stated Patient #57 became combative and aggressive. A verbal order by the PCP for "Haldol 5 mg IV now" was documented on 11/27/09 at 5:15 PM. A form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form", dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at	A 166	Nursing staff were in-serviced 2/17/10 regarding the use of drugs as a form of restraint and a video and test has been set-up on our education computer system, HealthStream, which will be required for clinical and housekeeping employees to have done by 2/26/2010.	

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A 166	Continued From page 28 8:10 AM, 12:00 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. An order, dated 11/28/09 but not timed, stated "Haldol 10 mg IM every 4 [hours as needed] Ativan 1 mg IM every 4 [hours as needed]." A physician progress note, dated 11/28/09 at 4:25 PM, stated "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." Patient #57 received the following medications: Haldol 5 mg IV at 5:48 PM on 11/27/09. Haldol 5 mg IM at 6:54 PM on 11/27/09. Haldol 10 mg IM at 5:14 AM on 11/28/09. Haldol 10 mg IM at 11:32 AM on 11/28/09. The use of physical restraints was not documented. The "Patient's Plan of Care", dated 11/28/09, stated Patient #57 was at "High Risk: Violence." The plan contained items such as establishing a behavior contract and setting limits on maladaptive behavior. The POC did not address the use of restraints. This was confirmed by interview with the ICU Nurse Manager/EMR Manager on 1/15/09 at 11:15 AM. Patient #57's POC was not modified to include the use of restraints. The hospital failed to ensure hospital staff had incorporated restraint usage into each patient's	A 166	Attached as exhibit 9 is a copy of Madison Memorial Hospital's recently revised restraint policy. This policy was approved 2/22/2010. All patient care staff have been educated on this policy and their responsibilities in this regard and a video and test has been set-up on our education computer system, which will be required for clinical and housekeeping employees to have done by 2/26/2010. Particular attention was made to the necessity of updating the plan of care of any patient in restraints.	

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A 166	Continued From page 29 plan of care.	A 166		
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, hospital policies, and incident reports, the hospital failed to ensure restraint orders were not written as prn orders for 2 of 5 patients (#56 and #57) whose records were reviewed for restraints. This resulted in in the use of restraints without consulting the physician, a violation of patient rights. It had the potential to interfere with patient safety. Findings include: A hospital policy, "Restraints-Management of Violent or Self-destructive Patient Behavior," dated 8/11/08, stated a physical restraint was any method or physical or mechanical devices that restricted freedom of movement. It also stated that a chemical restraint was a medication used in addition to, or in replacement of patient's regular drug regimen to control extreme behavior. The policy further stated that orders for restraints would never be written as a standing order or on a PRN basis. This policy was not followed. Examples include: 1. Patient #57's medical record documented an 85 year-old male who was admitted to the hospital on 11/27/09. The ED physician's "Clinical Report," dated 11/27/09, stated the patient's diagnoses included "Changed mental status. Dementia. Rule out cerebrovascular accident." A nursing note, dated 11/27/09 at 5:00	A 169	Attached here as exhibit 9 is a copy of the recently enacted policy on restraints. A letter was sent to all medical staff members in-servicing them on this policy on 2/18/2010 with particular attention made to not writing restraint orders as PRN. Attached here to as exhibit 15 is a copy of this letter. Ongoing medical staff restraint training will be conducted annually as the policy comes up for review.	

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A 169	Continued From page 30 PM, stated Patient #57 became combative and aggressive. A verbal order by the PCP for "Haldol 5 mg IV now" was documented on 11/27/09 at 5:15 PM. A form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form", dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at 8:10 AM, 12:00 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. An order, dated 11/28/09 but not timed, stated "Haldol 10 mg IM every 4 [hours as needed] Ativan 1 mg IM every 4 [hours as needed]." A physician progress note, dated 11/28/09 at 4:25 PM, stated "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." Patient #57 received the following medications: Haldol 5 mg IV at 5:48 PM on 11/27/09. Haldol 5 mg IM at 6:54 PM on 11/27/09. Haldol 10 mg IM at 5:14 AM on 11/28/09. Haldol 10 mg IM at 11:32 AM on 11/28/09. The use of physical restraints was not documented. The presence of the prn restraint orders was confirmed by interview with the ICU Nurse Manager/EMR Manager on 1/15/09 at 11:15 AM.	A 169	The necessity of monitoring patients in restraints was a specific part of staff in-service on 2/17/2010. Attached here as exhibit 10 is an outline of the education performed on that date.	

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A 169	Continued From page 31 2. Patient #56's medical record documented an 84 year-old female who was admitted to the hospital on 1/04/10 for pneumonia, and was a current patient as of 1/07/10. A physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was confused, agitated, and demanding to go home. A second physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was "more" agitated and uncooperative. He wrote that Patient #56 was now "throwing things." He noted that he was going to order Zyprexa. Zyprexa was an atypical antipsychotic, approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia and bipolar disorder. A nursing note dated 1/06/10 at 1:45 PM, stated Patient #56 was very anxious, combative and cooperative. The nurse stated that they walked Patient #56 around the halls at which Patient #56 was hitting and biting at the nurses. A pharmacy "Medications" audit sheet documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa Zydis 5 mg twice a day as needed. This order was discontinued on 1/06/10 at 2:49 PM. The pharmacy "Medications" audit sheet also documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa 5 mg intramuscular twice a day as needed. This order was discontinued on 1/06/10 at 2:50 PM. The original orders could not be found at the time of the survey. The Medical/ICU Manager, and the hospital's Clinical Educator reviewed the record on 1/07/10 at 2:30 PM, and also could not find the orders. On 1/06/10 at 2:45 PM, the physician ordered Zyprexa 5 to 10 mg by mouth three times a day	A 169	Attached hereto as exhibit 14 are copies of the orders written for both Zyprexa (0430) and Valium (0515). These orders were in the patient's medical record on the date the surveyors were here. The patient had been discharged on that date and her complete medical record was not on the unit, but in the medical records department when we received the call asking us to find them. We apologize that hospital staff did not retrieve the record from the medical records department.	

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A 169	Continued From page 32 as needed. This was documented on a physician's order sheet. Patient #56 was given Zyprexa 5 mg on 1/06/10 at 12:09 PM, 2:48 PM (which Patient #56 then threw out), and again at 5:33 PM according to the patient's Medication Administration Record. The RN who worked with Patient #56 on 1/06/10 starting at 1:10 PM, was interviewed. The medication orders were reviewed. She stated that she did not know that using Zyprexa to control the patient's behaviors was considered a chemical restraint. The hospital failed to ensure restraint orders were not written as prn orders.	A 169		
76	482.13(e)(11) PATIENT RIGHTS: RESTRAINT OR SECLUSION Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies, the hospital failed to ensure a process was in place to validate physicians and other licensed independent practitioners had a working knowledge of the hospital's policy regarding the use of restraints. This impacted 2 of 2 physicians (Physician C and H) who were interviewed. It had the potential to impact all physicians and licensed	A 176	Attached here as exhibit 9 is a copy of the recently enacted policy on restraints. A letter was sent to all medical staff members in-servicing them on this policy on 2/18/2010. Attached here to as exhibit 15 is a copy of this letter. Ongoing medical staff restraint training will be conducted annually as the policy comes up for review.	

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A 176	Continued From page 33 indepedent practitioners involved with retraint use in the hospital. A failure to ensure physicians and licensed independent practitioners had a working knowledge of restraint use had the potential to interfere with quality and safety of patient care. Findings include: A hospital policy, "Restraints- Management of a Violent or Self-destructive Patient Behavior," dated and approved 8/11/2008, (section 13), reads "All staff who have direct patient contact will have ongoing education and training in the proper and safe use of restraints." The policy did not indicate that the expectations for physicians and licensed indepedent practitioners were any different than the hospital's expectations for nursing staff or allied health care staff who had their competencies validated. During an interview with the Chief Quality Officer on 1/07/10 at 3:45 PM, she stated she was in charge of physician credentialing and in four years she had never asked physicians regarding competencies related to restraints. She stated that there had been restraint education available to medical staff through meetings on Medicine/ICU, however physicians were not required to attend. Internal Medicine physicians were required to attend 50% of meetings. She said the physicians attended on a "hit and miss" basis, and there was no specific requirement for physicians to read the policies or demonstrate understanding or competency related to restraints. During an interview on 1/08/10 at 9:30 AM, an MD who was working in the ED (Physician H), stated although he had full privileges with the hospital, it had been years since he had written an order for	A 176		

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A 176	Continued From page 34 restraints. He stated he was aware the hospital had restraint protocols, and if he needed to be involved with restraints he would ask the Unit Clerk to pull the "packet" and he would follow the packet guidelines. He denied ever receiving any training or education related to restraints either in medical school, residency, or from the hospital. He stated the hospital may have made training available, he was not sure, but that if there had been training available, he had not attended. He stated he would primarily depend on the administration to make sure all appropriate paperwork was completed. During an interview on 1/08/10 at 9:35 AM, a Family Practice MD (Physician C) with full hospital privileges stated he had not dealt with restraints in "years." He thought he might have attended a restraint training a few years prior, but had not had to restrain any patients since the training. He reported being aware that the hospital had a restraint protocol. The hospital failed to ensure physicians and licensed independent practitioners had a working knowledge of hospital policy regarding the use of restraints.	A 176		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or	A 178		

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MADISON MEMORIAL HOSPITAL	450 EAST MAIN STREET REXBURG, ID 83440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 178	Continued From page 35 - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, incident reports and hospital policy, the hospital failed to ensure 2 of 2 patients (#56 and #57), who had restraints applied for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention. This resulted in the inability of the hospital to adequately assess patients for the causes of behaviors and to treatment alternatives. Findings include: The hospital's Restraints-Management of Violent or Self-destructive Patient Behavior policy, dated 8/11/08 stated a physician or other licensed independent practitioner must see and evaluate the need for a restraint within 1 hour after the initiation of the restraint. This policy was not followed. Examples include: 1. Patient #57's medical record documented an 85 year-old male who was admitted to the hospital on 11/27/09. The ED physician's "Clinical Report," dated 11/27/09, stated the patient's diagnoses included "Changed mental status. Dementia. Rule out cerebrovascular accident." A nursing note, dated 11/27/09 at 5:00 PM, stated Patient #57 became combative and aggressive and threatened staff with a pair of scissors. The note stated police were called and they subdued the patient. A verbal order by the PCP for "Haldol 5 mg IV now" was documented on 11/27/09 at 5:15 PM. A form "Restraint:	A 178	At the in-service on 2/17/10 particular emphasis was given to the special requirements and limitation imposed when restraints are used to manage violent or self destructive behavior. Attached here to as exhibit 10 is the outline for the in-service.	

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A 178	Continued From page 36 MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form," dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at 8:10 AM, 12:00 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. An order, dated 11/28/09 but not timed, stated "Haldol 10 mg IM every 4 [hours as needed] Ativan 1 mg IM every 4 [hours as needed]." No documentation was present in the medical record that Patient #57 was evaluated by a qualified person after the incident at 5:00 PM on 11/27/09, to determine why the patient was so agitated and combative. No documentation was present in the medical record that Patient #57 was evaluated by a qualified person to determine the extent of his injuries following the incident. The PCP's first progress note, dated 11/28/09 but not timed, stated "Fell last night & sustained [laceration] to head + chest contusion." Patient #57 received the following medications: Haldol 5 mg IV at 5:48 PM on 11/27/09. Haldol 5 mg IM at 6:54 PM on 11/27/09. Haldol 10 mg IM at 5:14 AM on 11/28/09. Haldol 10 mg IM at 11:32 AM on 11/28/09. The use of physical restraints was not documented.	A 178	Although patient #57 was evaluated in the ED MMH did in fact fail to document that intervention. Staff have been instructed on the importance of documenting all patient interventions and in particular those which require emergency room treatment. Attached as exhibit 16 is a copy of that memorandum.	

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A 178	Continued From page 37 A face to face evaluation by a qualified person was not documented following the use of these chemical restraints. A physician progress note, dated 11/28/09 at 4:25 PM, was noted in the record. It stated in its entirety, "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." No documentation was present in the medical record that Patient #57 was evaluated by a qualified person after the administration of the 4 chemical restraints on 11/27/09 and 11/28/09. This was confirmed by the ICU Nurse Manager/EMR Manager on 1/15/09 at 11:15 AM. 2. Patient #56's medical record documented an 84 year-old female who was admitted to the hospital on 1/04/10 for pneumonia, and was a current patient as of 1/07/10. A physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was confused, agitated, and demanding to go home. A second physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was "more" agitated and uncooperative. He wrote that Patient #56 was now "throwing things." He noted that he was going to order Zyprexa. Zyprexa was an atypical antipsychotic, approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia and bipolar disorder. A pharmacy "Medications" audit sheet documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa Zydis 5 mg twice a day as needed. This order was discontinued on 1/06/10 at 2:49 PM. The pharmacy "Medications"	A 178	Nursing staff were in-serviced 2/17/10regarding the use of drugs as a form of restraint and a training video and will take a test video. A test has been set-up on our education computer system, HealthStream, which will be required for clinical and housekeeping employees to have done by 2/26/2010. The recently enacted restraint policy, attached as exhibit 9, clearly identifies staff responsibilities in this regard.	

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A 178	Continued From page 38 audit sheet also documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa 5 mg intramuscular twice a day as needed. This order was discontinued on 1/06/10 at 2:50 PM. The original orders could not be found at the time of the survey. On 1/06/10 at 2:45 PM, the physician ordered Zyprexa 5 to 10 mg by mouth three times a day as needed. This was documented on a physician's order sheet. A nursing note dated 1/06/10 at 12:00 PM, stated Patient #56 was agitated and confused. The nurse stated Patient #56 was wanting to go to bed even though she was in bed. Patient #56 was looking for people that were not there. The nurse stated that they walked Patient #56 around the halls at which time Patient #56 tried to get in other patients' rooms, became combative and hit the nurse. Patient #56 was given Zyprexa 5 mg on 1/06/10 at 12:09 PM according to the patient's Medication Administration Record. The record did not contain a face-to-face evaluation by a qualified person. A nursing note dated 1/06/10 at 1:45 PM, stated Patient #56 was very anxious, combative and un-cooperative. The nurse stated that they walked Patient #56 around the halls at which time Patient #56 was hitting and biting at the nurses. Patient #56 was given Zyprexa 5 mg on 1/06/10 at 2:48 PM (which Patient #56 then threw out), and was then given Valium 5 mg on 1/06/10 at 3:03 PM according to the patient's Medication Administration Record. The record did not contain a face-to-face evaluation by a qualified person.	A 178	Attached hereto as exhibit 14 are copies of the orders written for both Zyprexa (0430) and Valium (0515). These orders were in the patient's medical record on the date the surveyors were here. The patient had been discharged on that date and her complete medical record was not on the unit, but in the medical records department when we received the call asking us to find them. We apologize that hospital staff did not retrieve the record from the medical records department.	

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A 178	Continued From page 39 The RN who worked with Patient #56 on 1/06/10 starting at 1:10 PM, was interviewed. She stated the only time the physician saw Patient #56 on 1/06/10 was around 5:00 PM. She stated that she did not know that using Zyprexa to control the patient's behaviors was considered a chemical restraint, so therefore she did not think to request a face-to-face evaluation by a qualified person. The hospital failed to ensure patients, who had restraints for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention.	A 178	Nursing staff were in-serviced 2/17/10regarding the use of drugs as a form of restraint and a video and test has been set-up on our education computer system, HealthStream, which will be required for clinical and housekeeping employees to have done by 2/26/2010. The recently enacted restraint policy, attached as exhibit 9, clearly identifies staff responsibilities in this regard.	
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on patient record review and staff interview, the hospital failed to track and analyze adverse patient events in 2 of 5 patients (#57 and #58) whose records documented the use of chemical and/or physical restraints. Failure to track and analyze adverse events resulted in missed opportunity for the hospital to evaluate processes of care and implement appropriate performance improvement measures to reduce the risk of future adverse events and improve quality and safety of patient care. Findings include: 1. Patient #58 was a 49 year-old female admitted on 11/18/09 to ICU for hypoxia, altered mental status, and aspiration pneumonia. She was	A 267		

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A 267	Continued From page 40 intubated and placed on a ventilator with wrist restraints ordered to prevent her from dislodging her endotracheal tube. She was intubated at 7:00 PM and restraints were documented as being applied at that time. Patient #58 was intubated and restrained for 4 days. There was sporadic documentation of Patient #58 being observed for safety, with the first documented observation at 11:00 PM, 4 hours after initiation of the restraints. Patient #58 suffered a deep vein thrombosis in her left upper arm which was identified and confirmed on 11/22/09; the same day restraints were discontinued. According to a National Institute of Health article, titled "Deep Venous Thrombosis and Pulmonary Embolism Following Physical Restraint," dated April, 2005; there is risk of deep vein thrombosis and pulmonary embolism associated with immobilization during physical restraint, despite no other pre-existing risk factors. In an interview with the Clinical Coordinator of the Medical Surgical and ICU on 1/7/10 at 4:10 PM, he reviewed Patient #58's record and verified that Patient #58 suffered a deep vein thrombosis. The Clinical Coordinator stated Patient #58 had a PICC in place in the left arm, and confirmed that no incident report had been made. He stated sometimes patients had complications associated with their hospitalization, and that perhaps the nurse that cared for Patient #58 felt the deep vein thrombosis was one such complication. He stated the incident report should have been completed at the time of discovery. 2. Patient #57's medical record documented an 85 year-old male who presented to the ED on	A 267	Effective 2/1/2010 Madison Memorial Hospital has added a QI indicator documenting "possible complication for patients in restraints" this indicator will be tracked for at least one year by the CQO.	

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A 267	Continued From page 41 11/27/09 at 11:23 AM. The ED physician conducted the H&P and admitted Patient #57 to the hospital under the care of the patient's PCP. The ED physician's "Clinical Report," dated 11/27/09, stated the patient's diagnoses included "Changed mental status. Dementia. Rule out cerebrovascular accident." Patient #57 was admitted to the medical floor. He was taken to radiology for an MRI. A nursing note, dated 11/27/09 at 5:00 PM, stated "Nurse was called by MRI tech and told that pt was combative and aggressive and nurse needed to take him back to room and calm him. Arrived downstairs and found pt to be agitated and threatening. Pt had scissors in hand and all attempts to calm him were not effective. Doctor [name] was called for 1 to 1 order as well as Haldol to calm the pt. Police were called by House Supervisor and pt hit officer on left ear. Pt taken to floor by officer, pt hit head on way down, creating a 1 inch laceration on the right forehead. Laceration cleaned with soap and water and dressed with bandage. 5 mg Haldol given IM by House Supervisor." A verbal order by the PCP for "2. Haldol 5 mg IV now. 3. Haldol 5 mg [by mouth every evening]. 4. Haldol 2.5 mg [by mouth every morning]" was documented on 11/27/09 at 5:15 PM. The order was not signed by the ordering physician until 12/18/09. A form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form", dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. The order did not include the dosages of	A 267	Effective 2/1/2010 Madison Memorial Hospital has added a QI indicator tracking any incidences of inpatients being seen in the ER to verify that all appropriate documentation has been done to document the care given in the ER..	

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A 267	Continued From page 42 the Haldol and Ativan. It was signed by the PCP but not dated or timed. No documentation was present in the medical record that Patient #57 was evaluated after the incident, to determine why the patient was so agitated and combative. No documentation was present in the medical record that Patient #57 was evaluated to determine the extent of his injuries following the incident. The PCP's first progress note, dated 11/28/09 but not timed, stated "Fell last night & sustained [laceration] to head + chest contusion." The note did not mention the physical or chemical restraints or the need for continued restraints. An incident report had been filled out describing events related to Patient #57's combativeness on 11/27/09. An entry on the incident report by the Safety Officer, dated 11/30/09 at 11:04 AM, stated "The patient became irritated and violent while in the radiology dept and thus this incident. The staff handled it appropriately, per protocol. In talking to the case managers and nursing staff, no staff members were harmed significantly." The entry did not comment on Patient #57's injuries or on the use of restraints. The Safety Officer was interviewed on 1/07/09 at 2:00 PM. She stated staff followed the the hospital protocol for violent patients by calling a "Code Armstrong" and then calling the police. She said the case was not reviewed in order to determine if staff could have intervened to prevent Patient #57's combativeness or if the patient had adequate supervision prior to his outburst. She said the case was not reviewed in order to determine if restraints had been used appropriately and according to hospital policies.	A 267	Effective 1/25/2010 any case of a patient who has to be subdued by law enforcement or security personnel will have a root cause analysis performed by CQO and reported to the performance improvement committee.	

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A 267	Continued From page 43 She said the case was not reviewed in order to determine if Patient #57 received adequate medical care following the incident. She said the case was not reviewed in order to determine what steps staff could take to prevent future incidents. The hospital did not adequately analyze the adverse patient event.	A 267		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure medical records were accurately written and all care or orders were completely documented in 3 of 50 patients (#7, #56, and #57) whose medical records were reviewed. This had the potential to negatively impact coordination, quality, and safety of patient care. Findings include: 1. Patient #7 was a 62 year-old male admitted on 12/22/09 for a RIGHT knee joint replacement. A Physical Therapy not, dated 12/24/09, documented the physical therapist provided passive range of motion (PROM) on Patient #7's LEFT knee. The discharge summary, dated 12/25/09 documented Patient #7 had undergone a right knee arthroplasty. During an interview on	A 438	All staff have been re-instructed on the necessity of accuracy in medical records particularly with regards to site and side. All other entries in this patient's medical record reflect the proper side. "Left" instead of "Right" is simply a scrivener, error perhaps somewhat akin to the word "not" mistakenly, being used for the work "Note" as was done by whoever prepared this report.	

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A 438	Continued From page 44 1/05/10 at 3:30 PM, the Chief Quality Officer reviewed the record and stated she hoped the physical therapist just made a charting error and did not actually do therapy on the wrong knee. The hospital failed to ensure the medical record was accurately written. 2. Patient #56's medical record documented an 84 year-old female who was admitted to the hospital on 1/04/10 for pneumonia and had a history of dementia. Patient #56 was a current patient as of 1/07/10. Patient #56's medical record contained a pharmacy "Medications" audit sheet that documented on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa Zydis 5 mg twice a day as needed. This order was discontinued on 1/06/10 at 2:49 PM. The pharmacy "Medications" audit sheet also documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa 5 mg intramuscular twice a day as needed. This order was discontinued on 1/06/10 at 2:50 PM. The original orders could not be found at the time of the survey. A nursing note dated 1/06/10 at 5:15 AM, stated Patient #56's physician was called to obtain IV medications because the patient was refusing to take medication by mouth or injection. Patient #56 was given Valium 5 mg IV on 1/06/10 at 5:38 AM according to the patient's Medication Administration Record. The original orders could not be found at the time of the survey. The Medical/ICU Manager, and the hospital's Clinical Educator reviewed the record on 1/07/10 and also could not find the medication orders.	A 438	Attached hereto as exhibit14 are copies of the orders written for both Zyprexa (0430) and Valium (0515). These orders were in the patient's medical record on the date the surveyors were here. The patient had been discharged on that date and her complete medical record was not on the un, but in the medical records department when we received the call asking us to find them. We apologize that hospital staff did not retrieve the record from the medical records department.	

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A 438	Continued From page 45 The hospital failed to ensure the medical record documented all physician orders. 3. Patient #57's medical record documented an 85 year-old male who presented to the ED on 11/27/09 at 11:23 AM. The ED physician's "Clinical Report," dated 11/27/09, stated the patient's diagnoses included "Changed mental status. Dementia. Rule out cerebrovascular accident." Patient #57 was admitted to the medical floor. He was taken to radiology for an MRI at 4:00 PM. A nursing note, dated 11/27/09 at 5:00 PM, stated "Nurse was called by MRI tech and told that pt was combative and aggressive and nurse needed to take him back to room and calm him. Arrived downstairs and found pt to be agitated and threatening. Pt had scissors in hand and all attempts to calm him were not effective. Doctor [name] was called for 1 to 1 order as well as Haldol to calm the pt. Police were called by House Supervisor and pt hit officer on left ear. Pt taken to floor by officer, pt hit head on way down, creating a 1 inch laceration on the right forehead. Laceration cleaned with soap and water and dressed with bandage. 5 mg Haldol given IM by House Supervisor." No documentation was present in the medical record that Patient #57 was evaluated by a physician or other person to determine the extent of his injuries following the incident. Also, the form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form," dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and	A 438	Attached as exhibit 17 is the recently approved policy for documentation in the medical records. All clinical staff including medical staff were in-services on this policy. In addition proper physician documentation and authentication of all medical records has been added as a QI indicator which will be monitored at least for the next six months by the Health Information Management Director. Monitoring of hospital clinical staff documentation will be done by the individual department educators and reported to the performance improvement committee on a monthly basis for at least the next 6 months.	

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A 438	Continued From page 46 Ativan. The order did not include the dosages of the Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at 8:10 AM, 12:00 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. A physician signed all 4 renewals. A physician progress note, dated 11/28/09 at 4:25 PM, stated "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." No documentation was present in the medical record that the patient was physically restrained. A rationale for obtaining and renewing the order for physical restraints but not using them was not documented. The Clinical Coordinator for Intensive Care was interviewed at 11:15 AM on 1/15/10. She stated Patient #57 was treated in the ED following the incident. She stated he was seen by the ED physician. She said Patient #57's examination and treatment in the ED was not documented. She confirmed a note by the House Supervisor was not documented. She also stated the use of restraints was not thoroughly documented. Finally, she said the ED physician had conducted a face to face evaluation of the patient following the use of restraints. This was not documented. The hospital failed to document events surrounding the incident and the use of restraints.	A 438	Further Madison Memorial Hospital has re-written its policy on restraints which is attached here to as exhibit 9. Staff have been in-service on this policy on 2/17/2010 and a video and test has been set-up on our education computer system, HealthStream, which will be required for clinical and housekeeping employees to have done by 2/26/2010. The "use of restraints" has been added as a QI indicator, which will be monitored for at least the next 6 months by the Performance Improvement Director. Attached is exhibit 10, which is an outline of the in-service given on 2/17/2010.	
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service	A 450		

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A 450	Continued From page 47 provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and hospital policies, it was determined the hospital failed to ensure patient medical records were complete, dated, and timed in 5 of 50 patients (#3a, #7, #19, #56, and #57) whose records were reviewed. This resulted in a lack of clarity as to the timeline of care, which had the potential to interfere with patient safety and quality of care. Findings include: On 1/05/10 at 1:05 PM, the PI Manager was given a list of policies needed for review. Among the list were any policies that related to expectations for documentation in the medical record. A hospital policy was provided titled "Assembly and Analysis of Medical Records," dated 1/29/09, stated "all physician entries shall be signed, timed, and dated." The policy did not address address the expectation that entries other than physician entries in the medical record be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. This failure to express clear expectations to all patient care staff may have contributed to the failure to document date and time in medical record entries involving staff other than physicians. During an interview on 1/07/10 at 3:50 PM, the Chief Nursing Officer stated she was not aware of any specific policy that addressed documentaion guidelines for nursing staff as they related to making corrections or dating and timing entries. She stated she believed staff got training during orientation as new employees but was not certain of the specific training related to documentation.	A 450	Attached as exhibit 17 is the recently approved policy for documentation in medical records. All clinical staff including medical staff were in-service on this policy on 3/01/10. In addition proper documentation and authentication of all medical records has been added as a QI indicator which will be monitored at least for the next six months by Sandra Johnson, Health Information Management Director.	

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A 450	Continued From page 48 1. Patient #57's medical record documented an 85 year-old male who presented to the ED on 11/27/09 at 11:23 AM. The ED physician conducted the H&P and admitted Patient #57 to the hospital under the care of the patient's PCP. A nursing note, dated 11/27/09 at 5:00 PM, stated "Nurse was called by MRI tech and told that pt was combative and aggressive and nurse needed to take him back to room and calm him. Arrived downstairs and found pt to be agitated and threatening...Police were called by House Supervisor and pt hit officer on left ear. Pt taken to floor by officer, pt hit head on way down, creating a 1 inch laceration on the right forehead. Laceration cleaned with soap and water and dressed with bandage." The PCP's first progress note, dated 11/28/09 was not timed. It stated "Fell last night & sustained [laceration] to head + chest contusion." An X-ray report, dated 11/28/09, contained the findings of a chest X-ray. The report did not state what time the X-ray was taken. It stated it was signed by the radiologist at 5:16 PM on 11/29/09. An interview was conducted with the PI manager on 1/13/10 at 8:55 AM. He reviewed the computerized medical record and confirmed the time the X-ray was taken was not documented. Patient #57's medical record contained entries which were not timed. 2. Patient #56's medical record documented an 84 year-old female who was admitted to the hospital on 1/04/10 for pneumonia and had a history of dementia. Patient #56 was a current patient as of 1/07/10.	A 450		

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A 450	Continued From page 49 Patient #56's medical record contained two physicians' progress notes that were not timed. Both progress notes were dated 1/06/10. One note stated Patient #56 was confused, agitated, and demanding to go home. The second progress note stated Patient #56 was "more" agitated and uncooperative. The Medical/ICU Manager, and the hospital's Clinical Educator reviewed the record on 1/07/10 at 2:30 PM and confirmed the notes were not dated. 3. Patient #7 was a 62 year-old male admitted on 12/22/09 for a RIGHT knee joint replacement. An "Authorization for Operation, Procedure, or Treatment," dated 12/18/09, for patient #7 was not timed. During an interview on 1/05/10 at 3:30 PM, the Chief Quality Officer reviewed the record and confirmed the authorization form was untimed. 4. Patient #19 was a 66 year-old male admitted on 11/16/09 for left knee surgery. A treatment consent was signed by the patient but not dated. In addition, an "Authorization for Operation, Procedure, of Treatment," dated 11/12/09 was not timed. Anesthesia orders for Patient #19, dated 11/12/09 at 11:10 AM, were crossed out without being initialed, dated, or an explanation for the cross outs. During an interview on 1/06/10 at 10:30 AM, the Chief Nursing Officer reviewed the record and confirmed the incomplete entries. 5. Patient #3a was a newborn female born on	A 450	Attached here to as exhibit 18 is the recently approved policy on consents and staff have been in-serviced on this policy. Review for proper consent has been added as a QI indicator and will be tracked by the Performance Improvement Director for at least the next 6 months.	

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A 450	Continued From page 50 11/30/09. She was admitted directly to the NICU, and was discharged home at 18 days of age. Areas of concern were as follows: a. The infant had a security band placed after delivery, as there was a band number documented on the "Newborn Identification" sheet, undated. The document may also have been known as the "footprint" sheet. There was a set of footprints, and a print of "mother's" index finger. The sheet had the identification band number listed as 52753. The sheet contained areas for other details, such as birth date, time, sex of infant, weight, length, mother's hospital number. and infant's name. The areas were all left blank. b. The "Special Care Nursery Teaching-Discharge sheet had the mother's signature, but the area where the band number was to be written down was left blank, as was the area for the nurse signature, who was to verify the band and parent ID. c. The "Discharge Orders/Information Sheet" dated 12/18/__ (no year,) had only the mother's signature and not the discharging nurse signature. During an interview on 1/06/10 at 9:00 AM with the OB Manager, she reviewed the record and confirmed the ID numbers were conflicting, as well as the information needed on the forms was incomplete.	A 450	It is our protocol to document the baby's ID band # on the NICU Discharge Teaching Form, have the discharge nurse sign, and the mother or agent for the baby also sign this form. This was a case of the nurse charting that she did discharge teaching in her notes, but failed to fill out the Discharge Teaching Form appropriately per protocol. We addressed this problem in an e-mail to all NICU nurses upon receiving the findings from our Chief Nursing Officer. We addressed this issue in our NICU staff meeting on January 27, 2010. Training was done on the importance of and how to fill out this form in this meeting. It was also found that the Footprint sheet was not filled out and the security band # was transposed incorrectly on this sheet. We have revised the Newborn Identification Form, which was approved on January 21, 2010. See exhibit 13 for a copy of this form. We reduced the amount of information lines and consolidated the information with placing the mom and infant's admission sticker on the form along with a signature from the person taking the prints. We feel that the information now provided will meet the objectives of this form.	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of	A 724		

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A 724	Continued From page 51 safety and quality. This STANDARD is not met as evidenced by: Based on observations, staff interview, and review of hospital policy, it was determined the hospital failed to ensure supplies and equipment were maintained at an acceptable level of safety and quality for 4 of 10 departments (Inpatient Surgery, Outpatient Surgery, Medical/Surgical, and the Laboratory). The failure to maintain supplies and equipment had the potential to directly injure or expose patients to illnesses. The findings include: 1. During tours of the hospital's inpatient/outpatient surgery departments, on 1/06/10 starting at 9:30 AM and ending at 12:00 PM, concerns with bio-medical safety and quality testing, equipment cleaning and disinfecting, and expired supplies were noted as follows: a. During an observed tonsillectomy and adenoidectomy in the hospital's inpatient surgery center, on 1/06/10 starting at 8:20 AM, a Baxter Infusion Pump, ID #2209, was observed infusing diprivan (an intravenous sedative-hypnotic agent used for the induction and maintenance of anesthesia or sedation). The Bio-Medical safety and quality sticker on the pump stated the pump was last checked for safety and quality on 4/08, and expired on 9/08. Without current inspections of medical equipment, the facility would not be able to ensure safe operation. The hospital failed to ensure equipment was maintained at an acceptable level of safety and quality. b. During a tour of the hospital's inpatient surgery	A 724	On (enter date) we acquired a new computer program to track the Bio-medical equipment. On (enter date) all pieces of equipment were entered into the system. With this system we have the ability to run a daily report to see what equipment needs to be calibrated. This report will be run by the Bio-Med Tech and assignments will be made at the Engineering morning meeting. We have created a report that will be printed the beginning of the month showing any Bio-medical PM's that were not done. In the event that there is a piece of equipment that was not checked during the month this equipment will receive first priority to ensure that we keep it inspected as scheduled. This report will be sent to the Engineering Supervisor and it will be discussed in the morning Engineering meetings to ensure that all equipment are current. RF tags have been purchased and are being placed on equipment as they come due for calibration to help track the location of equipment, which will help with not being able to find the equipment that is due for service.	

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A 724	Continued From page 52 department, on 1/06/10 starting at 9:30 AM and ending at 11:40 AM, a Dyonics 25 Fluid Management System, ID #361, (used for arthroscopic procedures) was observed. The equipment's safety and quality testing sticker documented it was due for testing by Bio-Engineering on 8/08. On 1/06/10 starting at 11:25 AM, a Bio-Engineering employee was interviewed. He stated the hospital's computer software was outdated and he could not track when all of the hospital's medical equipment was due for safety and quality testing. He stated it was up to nursing staff to identify and send down equipment that needed to be re-checked, and that nursing staff should never use equipment that had an expired safety and quality testing sticker. The hospital failed to ensure equipment was maintained at an acceptable level of safety and quality. c. The hospital's Crash Cart Inventory and Locking policy, dated 4/17/09, stated that nursing was to check the crash cart's defibrillator every 12 hours for quality (a defibrillator delivers a therapeutic dose of electrical energy to a patient's heart when they are in cardiac arrest). During a tour of the hospital's inpatient surgery department on 1/06/10 at 9:54 AM, the PACU's December 2009's Crash Cart Log was reviewed. The record documented that nursing staff had not followed the hospital's Crash Cart Inventory and Locking policy; and did not check the PACU's defibrillator every 12 hours on 12/01-12/06, 12/10-12/13, 12/15, 12/17, 12/19-12/20, 12/24-12/27, and 12/30-12/21/09. This was confirmed by the	A 724		

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A 724	Continued From page 53 Surgical Unit's Manager on 1/06/10 at 9:54 AM. Without current testing of medical equipment, the facility would not be able to ensure safe operation. The hospital failed to ensure equipment was checked for an acceptable level of safety and quality. d. During a tour of the hospital's inpatient surgery department on 1/06/10 starting at 11:00 AM, a dirty utility room was observed. The room was being used to clean endoscopes used for colonoscopies and endoscopies. A sink was observed to contain a scope soaking in water and possibly detergent. The detergent being used was called Endozime AW, and the label directions for the detergent was to add 1.5 ounces to every gallon of water. However, the dirty utility room did not contain any measuring devices. The use of under diluted detergent could result in patient infections. The Central Sterilization Director was interviewed on 1/06/10 starting at 11:02 AM. She did not know that the detergent was to be mixed using 1.5 ounces of detergent to 1 gallon of water and could not ensure that staff had been following the detergent instructions. The hospital failed to ensure the inpatient surgical unit's medical equipment, in circulation for patient care, was checked and cleaned for acceptable levels of safety and quality. e. During a tour of the hospital's outpatient surgical department, on 1/06/10 starting at 12:00 PM and ending at 12:30 PM, 7 red top tubes, used to collect blood samples for laboratory	A 724	A measuring device was added to the endo room on 1/14/2010 and staff have been trained on the proper dilution of soap and water.	

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A 724	Continued From page 54 testing were observed. The red top tubes had expired on 7/08. Additionally, 3 green top tubes, also used to collect blood samples for testing, were expired as of 12/09. This was confirmed by the hospital's outpatient surgical department's Nurse Manager, who was present during the tour. The nurse manager discarded the expired tubes. The use of expired laboratory sample collection equipment could result in incorrect laboratory results. The hospital failed to ensure that the outpatient surgical department had ensured that all expired laboratory supplies, accessible for patient testing, were out of circulation. 2. During tours of the hospital's inpatient/outpatient surgery departments, on 1/06/10 starting at 5:30 PM and ending at 5:40 PM, concerns with bio-medical safety were noted as follows: During a tour of the hospital's Medical/Surgical Department, on 1/06/10 starting at 5:00 PM and ending at 5:40 PM, the following medical equipment did not have documented evidence of current safety and quality testing: a. Blanket Warmer, ID #0662, the Bio-Engineering sticker for safety and quality check expired on 9/09. b. Floor Fan, ID #0007, the Bio-Engineering sticker for safety and quality check expired on 8/08. c. Cardiac Portable Monitor, ID #0710, the Bio-Engineering sticker for safety and quality check expired on 12/08.	A 724	Madison Memorial Hospital has acquired a new computer program to track the Bio-medical equipment. On (enter date) all pieces of equipment were entered into the system. With this system we have the ability to run a daily report to see what equipment needs to be calibrated. This report will be run by the Bio-Med Tech and assignments will be made at the Engineering morning meeting. We have created a report that will be printed the beginning of the month showing any Bio-medical PM's that were not done. In the event that there is a piece of equipment that was not checked during the month this equipment will receive first priority to ensure that we keep it inspected as scheduled. This report will be sent to the Engineering Supervisor and it will be discussed in the morning Engineering meetings to ensure that all equipment are current. RF tags have been purchased and are being placed on equipment as they come due for calibration to help track the location of equipment, which will help with not being able to find the equipment that is due for service.	

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A 724	Continued From page 55 d. Intravenous infusion pump, serial #745468, did not to have an identification sticker or documented evidence of safety and quality testing. The use of medical equipment that had not been routinely checked for quality and safety could result in patient injury. The lack of current safety and quality testing was confirmed by the Medical/ICU Manager during the tour, and the items were removed from patient care areas. The hospital failed to ensure equipment in the Medical/Surgical unit, in circulation for patient care, was checked for acceptable levels of safety and quality. 3. During a tour of the hospital's laboratory, on 1/07/10 starting at 2:20 PM and ending at 3:50 PM, concerns with bio-medical safety and quality testing, equipment calibration, and expired supplies were noted as follows: a. The Stat Spin Express 4 centrifuge, Universal 320 centrifuge, Helmer Platelet Rotator, and a Helmer Frozen Fresh Plasma warmer were observed not to have an Bio-Medical safety and quality sticker. This could result in incorrect laboratory results and/or processes. On 1/07/10 at 3:50 PM, the Bio-Engineering Manager stated he did not know if the equipment had been checked by his department for safety and quality. He stated he had no way to track the over 4000 pieces of medical equipment in the hospital to ensure routine safety and quality testing was completed due to an outdated computer program.	A 724		

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A 724	Continued From page 56 The hospital's Bio-Engineering department failed to ensure that all laboratory equipment had been routinely tested for safety and quality, which could result in incorrect laboratory results and/or processes. b. MLA Pipettes were not apprpriately calibrated, as described below. An MLA Pipette was a pipette that consistently drew up and delivered a standard, preset, calibrated volume of fluid whenever it's plunger was depressed. The MLA Pipette could be set to aspirate one individual unit of fluid from 1ul (microliter 0.000001 liter) to 1000ul. MLA Pipettes were used to add chemical reagents to blood, urine and/or other laboratory specimens for laboratory testing. The use of un-calibrated MLA Pipettes could result in incorrect laboratory results. A Technical Service representative of the MLA Pipette distributors was interviewed on 1/08/10 starting at 10:20 AM. She stated the MLA Pipette should be checked for accurate unit calibration every 6 months. The Laboratory Manager was asked for the calibration records for the pipettes on 1/07/09. A note was received on 1/08/10 at 8:00 AM, from the Laboratory Manager stating she did not have any records for the calibrations of the pipettes. The pipettes were examined on 1/08/10 at 10:10 AM, and the following was noted: Pipette #1 contained a sticker that documented it was last calibrated on 12/13/04. Pipette #2 contained a sticker that documented it	A 724		

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A 724	Continued From page 57 was last calibrated on 6/26/01. Pipette #9 contained a sticker that documented it was last calibrated on 11/18/09. Pipette #11 contained a sticker that documented it was last calibrated on 12/13/04. Pipette labeled #13 contained a sticker that documented it was last calibrated on 12/13/04. Pipette #15 contained a sticker that documented it was last calibrated on 6/26/01. Eight other pipettes observed to be in use, did not have stickers documenting as to when they were last calibrated. A Medical Technologist was interviewed on 1/08/10 at 10:00 AM. He stated that another Medical Technologist, who no longer worked there, was the last person that he knew of that had checked the calibration of the pipettes. On 1/08/10 at 11:07 AM, the Bio-Engineering Manager stated that he was unsure who was responsible for checking the calibration of the laboratory's MLA Pipettes. The hospital's laboratory failed to ensure that staff had routinely checked MLA Pipettes of correct calibration. The use of un-calibrated MLA Pipettes could result in incorrect laboratory results. c. During a tour of the hospital's laboratory, on 1/07/10 starting at 2:20 PM and ending at 3:50 PM, 4 blue top tubes, used to collect blood samples for testing, were noted in the hospital's	A 724		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 724	Continued From page 58 laboratory processing refrigerator. The tubes had expired on 8/09. The use of expired laboratory sample collection equipment could result in incorrect laboratory results. The Laboratory Manager, who was present during the tour, confirmed the tubes were expired and discarded the tubes. The hospital failed to ensure the Laboratory Department's expired supplies were removed from use. The hospital failed to ensure supplies and equipment where maintained at an acceptable level of safety and quality.	A 724		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observations, staff interview, and review of hospital policy, it was determined the hospital failed to ensure that hospital kitchen staff practiced and enforced infection control interventions to prevent the possible spread of infections. The failure to maintain supplies and food to prevent the growth of bacteria had the potential to directly expose patients to illnesses. The findings include: 1. During a tour of the hospital's kitchen, on 1/06/10 starting at 2:00 PM and ending at 5:30 PM, concerns the Dietary Department's supplies and equipment noted as follows:	A 749	The Infection Control Officer now has an Excel file on system that has employee illness documented to track related incidents of infections and communicable diseases. This report includes infections that may be infectious that employees have. All managers were trained January 26, 2010 on what diseases or symptoms needed to be reported from their employees. On January 29, 2010, e-mails were also sent to the managers and employees asking that they send the a list to Infection Control each month for the previous months employee absenteeism for illnesses. See attached Exhibit 20 for a copy of the e-mails and Employee Illness Report.	

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	130025	A. BUILDING _____ B. WING _____	01/12/2010

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A 749	Continued From page 59 The hospital's Food Storage, Temperature Compliance, Temperature Logs, and Disposition policy, dated 2/11/08, stated "Containers will be clearly labeled and dated." The failure to not cover stored food increases the risk of food safety and quality. Uncovered food has a potential for cross-contamination of food borne bacteria. The failure to date food increased the risk of poor food safety and quality as the facility could not ensure that food was discarded within 7 days from when the food was opened. The hospital's Dietary Department-Infection Control Policy, dated 11/23/09, stated foods shall be stored covered, labeled and dated. This policies were not complied with as followed: a. During a tour of the hospital's kitchen, on 1/06/10 starting at 2:00 PM and ending at 5:30 PM, the following food was observed to be uncovered and/or unlabeled: Freezer #1, pizza sticks were uncovered. Refrigerator #2, a tray of pre-cut pieces of cake was uncovered. A tray of pre-cut pieces of cheesecake was unlabeled to include date of preparation and content. Refrigerator #7, containers of salsa, oatmeal, tarter sauce, bags of cheese and multiple containers used to restock the salad bar were unlabeled to include the date of preparation and the content. The kitchen's walk-in refrigerator contained an opened package of steaks, several opened packages of sandwich meats and a raisin filling	A 749	The dietary staff will be in-serviced on 2/25/10 on Infection control focusing on proper food labeling and date procedures. Attendance sheets and test scores will be used as proof of training. Daily monitoring using a monitor log will be done for 30 days following the in-service to assure compliance. Periodic spot checks will be done thereafter.	

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A 749	Continued From page 60 that were not labeled to include the date the contents were opened and the content. The above items were covered and/or discarded during the tour by the hospital's Dietary Manager. He confirmed the items should have been covered and/or labeled. The hospital failed to ensure kitchen staff had covered and/or labeled all food products to prevent cross-contamination and/or spoilage. b. During a tour of the hospital's kitchen on 1/06/10 at 2:00 PM, an employee was eating peanut butter in a food prep area. Eating in food preparation areas increases the potential risk of cross contamination of bacteria and employee illnesses. The kitchen employee stated on 1/06/10 at 2:00 PM, that she did not know that she was not allowed to eat food in the kitchen's food preparation areas. During a revisit to the hospital's kitchen on 1/07/10 at 8:20 AM, a second employee was noted eating French Toast as she prepared a consumer's breakfast. During an interview with the kitchen's Dietary Manager on 1/07/10 at 9:00 AM, he stated that kitchen employees should not be eating in the kitchen's food preparation area. The hospital failed to ensure kitchen staff did not consume food in food preparation. c. The hospital's Dietary Department-Infection Control Policy, dated 11/23/09, stated sinks should contain the proper dilution of quaternary ammonium as indicated by Eastern Idaho Public Health Department (240 parts per million).	A 749	Coaching in Action Forms have been filled out and presented to the two dietary employees in question on 1/12/10. Attached here as exhibit 21 is the Coaching in Action Form that is being used to address this issue with the employees. A review of the potential infection control risks of eating in food preparation areas will be covered as part of our dietary meeting held on 2/23/10. Daily the dietary manager will visually monitor for signs of food items being consumed in the food prep areas.	

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A 749	Continued From page 61 During a tour of the hospital's kitchen on 1/06/10 at 2:00 PM, a four compartment sink was observed. This sink was used to wash kitchen equipment. One sink was used to sanitize the equipment in quaternary ammonium. The quaternary ammonium was dispensed automatically through a system that mixed the quaternary ammonium with the water as it filled the sink. On 1/06/10 at 3:30 PM, the Dietary Manager was asked to provide a quaternary ammonium test strip (this strip checks the concentration on the quaternary ammonium in the water), he could not find any test strips. He stated that the quaternary ammonium system was checked monthly by an outside vender for accurate dilutions. He stated that neither he, nor any other staff had periodically checked the system in between the vender's visits to ensure the quaternary ammonium was adequately diluted. However, the hospital did have a Four Compartment Sink Temperatures Log that did prompt staff to check the quaternary ammonium concentration level. This form was not being utilized and was part of the hospital's Food Storage, Temperature Compliance, Temperature Logs, and Disposition policy, dated 2/11/08. The hospital's Kitchen Cleaning Instructions policy, dated 3/31/09, stated that mop buckets were to be filled with hot water and detergent, and to "Follow mixing instructions on detergent bottle." The hospital's Dietary Department-Infection Control Policy, dated 11/23/09, stated all work surfaces and floors would be cleaned daily with approved disinfectant.	A 749	Quaternary test strips were purchased on 01/09/10. An in-service was held on 01/28/10 addressing dilution ratios and temperature of sanitation solutions. This will also be a part of our scheduled infection control in-service held on 2/25/10 where we will review: "Food Storage, Temperature Compliance, Temperature Logs, and Disposition" focusing on quaternary dilution and monitoring in three compartment sinks and sanitation buckets. Attendance sheets and test scores will be used as proof of training. Daily monitoring using a monitoring log will be done for 30 days following the in-service to assure compliance. Weekly monitoring will be done by the dietary manager thereafter to assure long term compliance.	

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A 749	Continued From page 62 On 1/06/10 at 3:10 PM, during a tour of the kitchen, a mop bucket and mop detergent was observed. The directions listed on the detergent bottle directed to add 2 ounces of detergent to 1 gallon of water. The Dietary Manager was interviewed on 1/06/10 at 3:12 PM. He stated that when he mixes the detergent to water he just listens to the "glug glug" of the bottle and stops. A kitchen staff member, who mixes the mop water each morning, was interviewed on 1/06/10 at 3:15 PM. She stated that she "just pours in the detergent" and adds water. Additionally, on 1/06/10 at 2:10 PM, a cleaning bucket, that contained a bleach/water solution, was observed and tested. The test results documented the bleach solution was at 10 parts per million. The Dietary Manager stated at that time the solution was to be at 50 parts per million, and had a staff member remove the bucket. These practices could result into the under-disinfecting of surfaces while allowing bacteria to colonize at which could put patients health safety at risk. The hospital failed to ensure that kitchen staff had checked the quality of quaternary ammonium, bleach and detergent level qualities. The hospital failed to ensure that hospital kitchen staff practiced and enforced infection control interventions to prevent the possible spread of infections.	A 749	As part of the dietary infection control in-service which will be held on 2/25/10, focus will be made on kitchen cleaning instructions particularly on floor detergent dilution. Attendance sheets and test scores will be used as proof of training. Reminder signs have been posted in key areas addressing proper mop bucket dilution ratio. A measuring cup has been added to the mop room and staff have been trained on how to dilute mop water solution properly. New sanitation buckets have been ordered on 02/10/10 to ensure that sanitation solution is kept in an exclusive and safe container that is clearly labeled as sanitation solution. Proper dilution ratio labels will be attached to each sanitation bucket to assure the proper dilution ratio is mixed in the bucket. As part of the dietary infection control in-service which will be held on 2/25/10, focus will be made on kitchen cleaning instructions particularly on bleach dilution and monitoring of sanitation buckets. Attendance sheets and test scores will be used as proof of training. A permanent log has been made for the dietary employees to document testing of the bleach solution. This will be an on-going quality indicator.	
A 750	482.42(a)(2) INFECTION CONTROL LOG	A 750		

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A 750	Continued From page 63 The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases. This STANDARD is not met as evidenced by: Based on staff interview, it was determined the hospital failed to ensure the Infection Control Officer maintained a log that included staff related incidents of infections and communicable diseases. This resulted in an incomplete log and had the potential to reduce the hospital's ability to track and analyze infections and put in place appropriate measures to protect patients and staff from staff infections. Findings include: During an interview on 1/06/10 at 2:40 PM, the Infection Control Officer explained she kept an electronic log that contained information related to patient infections. She stated she did not include information related to employee infections/incidents electronically alongside the patient information. She kept a hard copy of information in individual employee files in her office. She denied there was any easily retrievable aggregate of employee infection-related information. When asked how she kept track of employee infections, she responded, "I keep it in my mind." The hospital failed to ensure the Infection Control Officer maintained a log that included staff related incidents related to infections and communicable diseases as they were identified through employee health services.	A 750	The Infection Control Officer now has an Excel file on system that has employee illness documented to track related incidents of infections and communicable diseases. This report includes infections that may be infectious that employees have. All managers were trained January 26, 2010 on what diseases or symptoms needed to be reported from their employees. On January 29, 2010, e-mails were also sent to the managers and employees asking that they send the a list to Infection Control each month for the previous months employee absenteeism for illnesses. See attached Exhibit 20 for a copy of the e-mails and Employee Illness Report.	
A 951	482.51(b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and	A 951		

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A 951	Continued From page 64 maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, it was determined the hospital failed to ensure that surgical services had developed and approved standing orders according to the hospital processes. The failure to ensure that standing orders were appropriately approved by the Surgical/Physical Therapy Committee. This resulted in standing orders being implemented without a complete professional staff review. This affected the health and safety of all surgical patients. The findings include: During a tour of the hospital's surgery department, on 1/06/10 starting at 9:30 AM and ending at 11:40 AM, and during a tour of the hospital's outpatient surgical department, on 1/06/10 starting at 12:00 PM and ending at 12:30 PM, standing PACU Recovery Orders were observed and reviewed. The orders stated: "Seizures: 1. Call Anesthesia Provider STAT (immediately) 2. Administer Oxygen as soon as possible (ASAP) 3. Propofol 20 mg IV push (May Repeat x 2) or Versed 3.0 mg IV push (May Repeat x 1)" According to document #451094A, Issued: February 2008, propofol was approved by the Food and Drug Administration, as an intravenous sedative-hypnotic agent for use in the induction and maintenance of anesthesia in surgery and for	A 951	The order for Propofal on the standing PACU Recovery Orders has been withdrawn. The hospital has established a policy for standing orders. See exhibit 19 for a copy of this policy.	

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A 951	Continued From page 65 chemical sedation in ICU. The Food and Drug Administration has not approved the use of Propofol for seizure control. The hospital's Diprivan (propofol) Protocol, dated 11/04/09, only approved the use of the medication for continuous IV sedation, anesthesia and for rapid intubation procedures. On 1/08/10 starting at 9:15 AM, a hospital Pharmacist was interviewed. He stated that he had never seen Propofol used to treat seizures nor was he familiar with the standing PACU Recovery Orders. On 1/08/10 starting at 9:06 AM, the hospital's Pharmacy Director was interviewed. He stated that he had never seen propofol used to treat seizures. The Pharmacist Director reviewed the PACU Recovery Orders and stated that he was not involved in the development and approval of the standing orders. He stated the standing orders were created by the OR Director, reviewed by the hospital's Performance Improvement secretary and approved by the hospital's Chief Nursing Officer. He stated that this process was not consistent with the hospital's procedures in approving standing orders. He stated that the last time the standing orders were documented as being reviewed was on 3/23/09. He stated when standing orders were developed that included medications, he was usually asked to review the orders. The hospital's Chief Nursing Officer was interviewed on 1/08/10 starting at 9:55 AM. She stated that, when a department developed a standing order, it was reviewed and approved by that department's committee. She could not find	A 951		

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A 951	Continued From page 66 in the 2009, Surgery/Physical Therapy Committee meeting notes that the PACU Recovery Orders were reviewed and approved by the Surgery/Physical Therapy Committee. She stated that the PACU recovery standing orders should have been reviewed and approved by that committee. She confirmed the committee had not approved the orders. On 1/13/10 at 9:40 AM, the hospital's Performance Improvement Manager was interviewed. He stated the Surgery/Physical Therapy Committee did meet quarterly to review any Surgery/Physical Therapy issues. He stated the committee consisted of the Chief Quality Officer, the Chief Nursing Officer, Chief Organizational Development Officer, Performance Improvement Director, Infection Control Director, the Operating Room Director, Assistant Surgical Nurse Manager, AMU/ASU/ICU Manager, Case Manager, Health Information Management Director, Anesthesia Manager, Director of Physical Therapy, Pharmacy Director (upon request), and committee members who were also members of the medical staff. The hospital failed to ensure that the Surgery/Physical Therapy Committee had reviewed and approved the Operating Room's PACU Recovery Orders to include the off label use of Diprivan (propofol).	A 951		

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the Medicare recertification survey of your hospital. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Teresa Hamblin, RN, HFS Susan Costa, RN, HFS	B 000	RECEIVED FEB 17 2010 FACILITY STANDARDS	
BB145	16.03.14.250.02 Medical Staff Appointments and Reappointments 02. Medical Staff Appointments and Reappointments. Medical staff appointments and reappointments shall be made by the governing body upon the recommendation of the active medical staff, or a committee of the active staff. (10-14-88) a. Appointments to the medical staff shall include a written delineation of all privileges including surgical procedures, and governing body approval shall be documented. (10-14-88) b. Reappointments to the medical staff shall be made at least every two (2) years with appropriate documentation indicating governing body approval. (10-14-88) c. Reappointment procedures shall include a means of increasing or decreasing privileges after consideration of the member's physical and mental capabilities. (10-14-88) d. The medical staff and administration with approval of the governing body shall develop a written procedure for temporary or emergency medical staff privileges. (10-14-88)	BB145	Effective 2/12/10 every credentialing file at Madison Memorial Hospital has been reviewed. Any file in which there is not a clear delineation of privileges for the practitioner is being re-done. Delineation of privileges have been approved for practitioner B, C, D, and E. Attached here to as exhibit 1 are copies of privilege request forms which are now used for every initial and re-credentialing appointment at Madison Memorial Hospital.	

Bureau of Facility Standards

LAB ORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PERFORMANCE IMPROVEMENT DIRECTOR — (X6) DATE: 2/16/10

STATE FORM 6899 QLUB11 If continuation sheet 1 of 10

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BB145	Continued From page 1 This Rule is not met as evidenced by: Refer to Tag A 046 as it relates to the failure of the hospital to ensure practitioners had been appointed to the medical staff and granted specific privileges defining their practice and a failure to the hospoital to implement a consistent process to request and grant privileges.	BB145		
BB174	16.03.14.310.02 Records 02. Records. Nurses shall maintain records that document patient status, progress and care given using descriptive measurable data. This documentation shall include but not be limited to: (10-14-88) a. Admission note; and (10-14-88) b. Vital signs; and (10-14-88) c. Medication record; and (10-14-88) d. Rationale for and results of PRN drug administration; and (10-14-88) e. Patient teaching; and (10-14-88) f. Adverse drug or blood reaction; and (10-14-88) g. Discharge note. (10-14-88) This Rule is not met as evidenced by: Refer to Tags A 0438 and A 0450 as they relate to the failure of the hospital to ensure that staff maintains records and accurate documentation with completed data including admission note, vital signs, medication records, patient teaching, and discharge note.	BB174	Attached as exhibit 17 is the recently approved policy for documentation in the medical records. All clinical staff including medical staff were in-services on this policy. In addition proper physician documentation and authentication of all medical records has been added as a QI indicator which will be monitored at least for the next six months by the Health Information Management Director. Monitoring of hospital clinical staff documentation will be done by the individual department educators and reported to the performance improvement committee on a monthly basis for at least the next 6 months.	

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BB208	Continued From page 2	BB208		
BB208	16.03.14.320.07 Food Preparation and Service 07. Food Preparation and Service. (10-14-88) a. The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. (10-14-88) b. Foods shall be stored, prepared and served following procedures which shall ensure the retention of their nutritive value. (10-14-88) This Rule is not met as evidenced by: Based on observations, staff interview, and review of hospital policy, it was determined the hospital failed to ensure that hospital kitchen staff stored food properly. This had the potential to compromise the safety and nutritional value of the food. The findings include: 1. During a tour of the hospital's kitchen, on 1/06/10 starting at 2:00 PM and ending at 5:30 PM, concerns the Dietary Department's supplies and equipment noted as follows: The hospital's Food Storage, Temperature Compliance, Temperature Logs, and Disposition policy, dated 2/11/08, stated "Containers will be clearly labeled and dated." The failure to not cover stored food increases the risk of food safety and quality. Uncovered food has a potential for cross-contamination of food borne bacteria. The failure to date food increased the risk of poor food safety and quality as the facility could not ensure that food was discarded within 7 days from when the food was opened. The hospital's Dietary Department-Infection Control Policy, dated 11/23/09, stated foods shall	BB208	The dietary staff will be in-serviced on 2/25/10 on Infection control focusing on proper food labeling and date procedures. Attendance sheets and test scores will be used as proof of training. Daily monitoring using a monitor log will be done for 30 days following the in-service to assure compliance. Periodic spot checks will be done thereafter.	

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BB208	Continued From page 3 be stored covered, labeled and dated. This policies were not complied with as followed: a. During a tour of the hospital's kitchen, on 1/06/10 starting at 2:00 PM and ending at 5:30 PM, the following food was observed to be uncovered and/or unlabeled: Freezer #1, pizza sticks were uncovered. Refrigerator #2, a tray of pre-cut pieces of cake was uncovered. A tray of pre-cut pieces of cheesecake was unlabeled to include date of preparation and content. Refrigerator #7, containers of salsa, oatmeal, tarter sauce, bags of cheese and multiple containers used to restock the salad bar were unlabeled to include the date of preparation and the content. The kitchen's walk-in refrigerator contained an opened package of steaks, several opened packages of sandwich meats and a raisin filling that were not labeled to include the date the contents were opened and the content. The above items were covered and/or discarded during the tour by the hospital's Dietary Manager. He confirmed the items should have been covered and/or labeled. The hospital failed to ensure kitchen staff had covered and/or labeled all food products to prevent cross-contamination and/or spoilage. b. During a tour of the hospital's kitchen on 1/06/10 at 2:00 PM, an employee was eating peanut butter in a food prep area. Eating in food preparation areas increases the potential risk of cross contamination of bacteria and employee	BB208	Coaching in Action Forms have been filled out and presented to the two dietary employees in question on 1/12/10. Attached here as exhibit 21 is the Coaching in Action Form that is being used to address this issue with the employees. A review of the potential infection control risks of eating in food preparation areas will be covered as part of our dietary meeting held on 2/23/10. Daily the dietary manager will visually monitor for signs of food items being consumed in the food prep areas.	

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BB208	Continued From page 4 illnesses. The kitchen employee stated on 1/06/10 at 2:00 PM, that she did not know that she was not allowed to eat food in the kitchen's food preparation areas. During a revisit to the hospital's kitchen on 1/07/10 at 8:20 AM, a second employee was noted eating French Toast as she prepared a consumer's breakfast. During an interview with the kitchen's Dietary Manager on 1/07/10 at 9:00 AM, he stated that kitchen employees should not be eating in the kitchen's food preparation area. The hospital failed to ensure kitchen staff did not consume food in food preparation. c. The hospital's Dietary Department-Infection Control Policy, dated 11/23/09, stated sinks should contain the proper dilution of quaternary ammonium as indicated by Eastern Idaho Public Health Department (240 parts per million). During a tour of the hospital's kitchen on 1/06/10 at 2:00 PM, a four compartment sink was observed. This sink was used to wash kitchen equipment. One sink was used to sanitize the equipment in quaternary ammonium. The quaternary ammonium was dispensed automatically through a system that mixed the quaternary ammonium with the water as it filled the sink. On 1/06/10 at 3:30 PM, the Dietary Manager was asked to provide a quaternary ammonium test strip (this strip checks the concentration on the quaternary ammonium in the water), he could not find any test strips. He stated that the quaternary ammonium system was checked monthly by an	BB208	Quaternary test strips were purchased on 01/09/10. An in-service was held on 01/28/10 addressing dilution ratios and temperature of sanitation solutions. This will also be a part of our scheduled infection control in-service held on 2/25/10 where we will review: "Food Storage, Temperature Compliance, Temperature Logs, and Disposition" focusing on quaternary dilution and monitoring in three compartment sinks and sanitation buckets. Attendance sheets and test scores will be used as proof of training. Daily monitoring using a monitoring log will be done for 30 days following the in-service to assure compliance. Weekly monitoring will be done by the dietary manager thereafter to assure long term compliance.	

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BB208	Continued From page 5 outside vender for accurate dilutions. He stated that neither he, nor any other staff had periodically checked the system in between the vender's visits to ensure the quaternary ammonium was adequately diluted. However, the hospital did have a Four Compartment Sink Temperatures Log that did prompt staff to check the quaternary ammonium concentration level. This form was not being utilized and was part of the hospital's Food Storage, Temperature Compliance, Temperature Logs, and Disposition policy, dated 2/11/08. The hospital's Kitchen Cleaning Instructions policy, dated 3/31/09, stated that mop buckets were to be filled with hot water and detergent, and to "Follow mixing instructions on detergent bottle." The hospital's Dietary Department-Infection Control Policy, dated 11/23/09, stated all work surfaces and floors would be cleaned daily with approved disinfectant. On 1/06/10 at 3:10 PM, during a tour of the kitchen, a mop bucket and mop detergent was observed. The directions listed on the detergent bottle directed to add 2 ounces of detergent to 1 gallon of water. The Dietary Manager was interviewed on 1/06/10 at 3:12 PM. He stated that when he mixes the detergent to water he just listens to the "glug glug" of the bottle and stops. A kitchen staff member, who mixes the mop water each morning, was interviewed on 1/06/10 at 3:15 PM. She stated that she "just pours in the detergent" and adds water.	BB208	As part of the dietary infection control in-service which will be held on 2/25/10, focus will be made on kitchen cleaning instructions particularly on floor detergent dilution. Attendance sheets and test scores will be used as proof of training. Reminder signs have been posted in key areas addressing proper mop bucket dilution ratio. A measuring cup has been added to the mop room and staff have been trained on how to dilute mop water solution properly.	

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BB208	Continued From page 6 Additionally, on 1/06/10 at 2:10 PM, a cleaning bucket, that contained a bleach/water solution, was observed and tested. The test results documented the bleach solution was at 10 parts per million. The Dietary Manager stated at that time the solution was to be at 50 parts per million, and had a staff member remove the bucket. These practices could result into the under-disinfecting of surfaces while allowing bacteria to colonize at which could put patients health safety at risk. The hospital failed to ensure that kitchen staff had checked the quality of quaternary ammonium, bleach and detergent level qualities. The hospital failed to ensure that hospital kitchen staff practiced and enforced infection control interventions to prevent the possible spread of infections.	BB208	New sanitation buckets have been ordered on 02/10/10 to ensure that sanitation solution is kept in an exclusive and safe container that is clearly labeled as sanitation solution. Proper dilution ratio labels will be attached to each sanitation bucket to assure the proper dilution ratio is mixed in the bucket. As part of the dietary infection control in-service which will be held on 2/25/10, focus will be made on kitchen cleaning instructions particularly on bleach dilution and monitoring of sanitation buckets. Attendance sheets and test scores will be used as proof of training. A permanent log has been made for the dietary employees to document testing of the bleach solution. This will be an on-going quality indicator.	
BB332	16.03.14.390.01 Anesthesia Services, Policies and Procedures 390. ANESTHESIA SERVICES. These services shall be available when the hospital provides surgery or obstetrical services with C-section capacity and shall be integrated with other services of the hospital and shall include at least the following: (10-14-88) 01. Policies and Procedures. Policies and procedures shall be approved by the medical staff and the administration of the hospital. These written policies and procedures shall include at least the following: (10-14-88) a. Designation of persons permitted to give anesthesia, types of anesthetics, preanesthesia, and post anesthesia responsibilities; and	BB332		

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BB332	Continued From page 7 (10-14-88) b. Preanesthesia physical evaluation of a patient by an anesthetist, with the recording of pertinent information prior to surgery together with the history and physical and preoperative diagnosis of a physician; and (10-14-88) c. Review of patient condition immediately prior to induction; and (10-14-88) d. Safety of the patient during anesthetic period; and (10-14-88) e. Record of events during induction, maintenance, and emergence from anesthesia including: (10-14-88) i. Amount and duration of agents; and (10-14-88) ii. Drugs and IV fluids; and (10-14-88) iii. Blood and blood products. (10-14-88) f. Record of post-anesthetic visits and any complications shall be made within three (3) to forty-eight (48) hours following recovery; and (10-14-88) g. There shall be a written infection control procedure including aseptic techniques, and disinfection or sterilizing methods. (10-14-88) This Rule is not met as evidenced by: Refer to Tag A 951 as it relates to the failure of the hospital to ensure that surgical services developed and approved standing orders according to the hospital processes, including approval by the medical staff and the administration of the hospital.	BB332	The order for Propofal on the standing PACU Recovery Orders has been withdrawn. The hospital has established a policy for standing orders. See exhibit 19 for a copy of this policy.	

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BB539	16.03.14.540.02 Infection Control Program 02. Infection Control Program. The program shall include at least the following elements: (10-14-88) a. Definition of nosocomial infection, as opposed to community acquired infections; and (10-14-88) b. A procedure for hospital surveillance of and for nosocomial infections; and (10-14-88) c. A procedure for reporting and evaluating nosocomial infections. The procedure must enable the hospital to establish the following on at least a quarterly basis: (10-14-88) i. Level or rate of nosocomial infections; and (10-14-88) ii. Site of infection; and (10-14-88) iii. Microorganism involved. (10-14-88) This Rule is not met as evidenced by: Refer to Tag A 0750 as it relates to the failure of the hospital to ensure an Infection Control Program which includes a tracking mechanism and log for employee infections, with a procedure to recover such information.	BB539	The Infection Control Officer now has an Excel file on system that has employee illness documented to track related incidents of infections and communicable diseases. This report includes infections that may be infectious that employees have. All managers were trained January 26, 2010 on what diseases or symptoms needed to be reported from their employees. On January 29, 2010, e-mails were also sent to the managers and employees asking that they send a list to Infection Control each month for the previous months employee absenteeism for illnesses. See attached Exhibit 20 for a copy of the e-mails and Employee Illness Report.	
BB540	16.03.14.540.03 Infection Control & Prevention Procedures 03. Infection Control and Prevention Procedures. There shall be a written infection control procedure which shall include aseptic techniques, cleaning, sanitizing, and disinfection of all instruments, equipment and surfaces, for all departments and services of the hospital where	BB540		

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BB540	Continued From page 9 patient care is rendered. (10-14-88) This Rule is not met as evidenced by: Refer to Tag A 0749 as it relates to the failure of the hospital to ensure a written infection control procedure which includes techniques for the disinfection, sanitizing, and cleaning of equipment, surfaces, and instruments for all all patient care departments.	BB540	Attached as exhibit 22 is our Infection Control: IDAPA Rules and Minimum Standards for Hospitals in Idaho policy. We are adding infection control procedures for General Surgery, Laboratory, Radiology, Emergency Room & Short Stay Therapy, Medical/Surgical/CCU, Labor and Delivery/Mother Baby Unit, Diabetes Education, ENT Clinic, General Surgery Clinic, Surgical Center, and the Pharmacy. These policies will be in the policy manual by 2/23/2010.	

MADISON
MEMORIAL HOSPITAL

Madison Memorial Hospital
450 East Main
Rexburg, ID 83440
(208) 356-3691

Date: 2-19-10

Time: 9:40

No. of Pages (including cover page): 19

To: Sylvia Creswell, Teresa Hamblin, Susan Costa

Fax #: (208) 364-1888 Phone #: (208) 334-6626

From: Department: Performance Improvement

Direct Dial Ph#: (208) 359-6488

Fax# (208) 359- 6413

Sending contact: Nolan J. Bybee

Subject: This is an addendum to the previous correction submission sent on 2-16-10 for the deficiencies related to Patient Grievance and Restraints.

Comments: I also attached a copy of the change we made to the restraint policy. Thank you for your understanding of this issue.

February 19, 2010

Bureau of Facility Standards
Teresa Hamblin, RN, Health Facilities Surveyor
3232 Elder St.
P.O. Box 83720
Boise, ID 83720-0036

Re: State Deficiency

Dear Ms. Hamblin,

On February 16, 2010 we submitted a Statement of Deficiency/Plan of Correction. Enclosed is an addendum correction to the report sent on February 16, 2010. Also enclosed is a copy of the restraint policy showing that the correction that needed made has been done. We want to thank you for the opportunity to improve our processes in the delivery of patient care.

If you have questions please contact Terry Conrad at (208) 359-9801 or Nolan Bybee at (208) 359-6488.

Respectfully,

Nolan Bybee, RRT, MBA
Performance Improvement Director

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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A 119	Continued From page 7 each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies and grievance-related documents, it was determined the hospital's governing body failed to review and resolve grievances or delegate the responsibility in writing to a grievance committee. This directly affected 12 of 12 patients (#46, #47, #48, #49, #50, #51, #52, #53, #54, #60, #61, and #62) whose grievances were reviewed. The hospital's governing body also failed to establish a grievance process/policy that ensured the hospital responded to all grievances in an appropriate manner. These failures resulted in an ineffective, inefficient, and inconsistent grievance process. Findings include: 1. The hospital's grievance policy, "Patient Concerns," dated 7/03/09, was approved by the Chief Executive Officer. The following problems were identified with the policy: a. The policy failed to identify the role of the governing body in reviewing or resolving grievances. b. The policy failed to reference the governing body's delegation of review and resolution of grievances to a grievance committee. It failed to reference the existence of a grievance committee. c. The definition of grievances described in the	A 119	This is an addendum to the previous correction submission sent on 2/16/10. I apologize for the confusion by originally attaching the restraint comment in this section. The comment should have read: Attached here as exhibit 7 is the new grievance policy for Madison Memorial Hospital which was presented to the board on February 18, 2010. A grievance committee has been formed.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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A 119	Continued From page 10 grievance process operated effectively.	A 119		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies, grievance-related documents, and incident reports, it was determined the hospital either failed to provide written responses or provided incomplete written responses to 12 of 12 patients (#46, #47, #48, #49, #50, #51, #52, #53, #54, #60, #61, and #62) and/or patient representatives whose grievances were reviewed. This resulted in a lack of clarity about whether the grievances had been thoroughly investigated and resolved. It had the potential to interfere with patient understanding and satisfaction. Findings include: Surveyors initially requested to view the grievance log for the last quarter of 2009 (October through December). Instead of being given the grievance log, the Chief Quality Office provided surveyors with the hand written and verbal recall of "Patient Concerns and Complaints" for the same time period. During an interview on 1/07/10 at 11:30 AM, the Chief Quality Officer explained that the hospital did not keep a grievance log or have dedicated files or forms for grievances. She further explained that instead of writing letters, the	A 123	This is an addendum to the previous correction submission sent on 2/16/10. I apologize for the confusion by originally attaching the restraint comment in this section. The comment should have read: Attached here as exhibit 7 is the new grievance policy for Madison Memorial Hospital which was presented to the board on February 18, 2010. A grievance committee has been formed. A grievance log has been created to track grievances and when the patient was sent a letter. This is being kept by the Chief Quality Officer.	

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A 144	Continued From page 18 to 3 of 50 patients (#3a, #57 and #58) whose medical records were reviewed. This resulted in injury to Patient #57 and the potential for injury to other patients. Findings include: 1. Patient #57's medical record documented an 85 year-old male who presented to the ED on 11/27/09 at 11:23 AM. The ED physician conducted the H&P and admitted Patient #57 to the hospital under the care of his PCP. The ED physician's "Clinical Report," dated 11/27/09, stated Patient #57's diagnoses included changed mental status, dementia, and rule out cerebrovascular accident. Patient #57 was admitted to the medical floor. He was taken to radiology for an MRI. A nursing note, dated 11/27/09 at 5:00 PM, stated "Nurse was called by MRI tech and told that pt was combative and aggressive and nurse needed to take him back to room and calm him. Arrived downstairs and found pt to be agitated and threatening. Pt had scissors in hand and all attempts to calm him were not effective. Doctor [name] was called for 1 to 1 order as well as Haldol to calm the pt. Police were called by House Supervisor and pt hit officer on left ear. Pt taken to floor by officer, pt hit head on way down, creating a 1 inch laceration on the right forehead. Laceration cleaned with soap and water and dressed with bandage. 5 mg Haldol given IM by House Supervisor." A verbal order by the PCP for "2. Haldol 5 mg IV now. 3. Haldol 5 mg [by mouth every evening]. 4. Haldol 2.5 mg [by mouth every morning]" was documented on 11/27/09.at 5:15 PM. The order was not signed by the ordering physician until 12/18/09.	A 144	This is an addendum to the previous correction submission sent on 2/16/10. Attached as exhibit 9 is a copy of Madison Memorial Hospital's recently revised restraint policy. This policy was approved 2/18/2010. Over 75% of our patient care staff have been educated on this policy and their responsibilities. Attached here as exhibit 10 is a copy of the PowerPoint portion of that in-service. Nursing staff have been in-serviced regarding the use of drugs as a form of restraint. A list of medications frequently known to be used as a chemical restraint has been identified and a question has been inserted into our nursing documentation to ask if these meds are being used as a restraint. The recently enacted restraint policy has been attached as exhibit 9, which clearly identifies staff responsibilities in this regard. The restraint policy was approved 2/18/2010 and over 75%of patient care staff have been educated on this policy and their responsibilities in this regard. The form of education was through viewing a video, power point of the standards, taking a test and return demonstration of soft restraint application. Particular attention was made to the nursing staff on the proper method of receiving a restraint order. Physicians have been trained on their role in restraint management.	

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A 166	Continued From page 25 hospital on 1/04/10 for pneumonia and had a history of dementia. Patient #56 was a current patient as of 1/07/10. Patient #56's medical record only contained two physician's progress notes. A physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was confused, agitated, and demanding to go home. A second physician's progress note, dated 1/06/10 that was not timed, stated Patient #56 was "more" agitated and uncooperative. He wrote that Patient #56 was now "throwing things." He noted that he was going to order Zyprexa. Zyprexa was an atypical antipsychotic, approved by the Food and Drug Administration (FDA) for the treatment of schizophrenia and bipolar disorder. A pharmacy "Medications" audit sheet documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa Zydis 5 mg twice a day as needed. This order was discontinued on 1/06/10 at 2:49 PM. The pharmacy "Medications" audit sheet also documented that on 1/06/10 at 6:30 AM, Patient #56 was prescribed Zyprexa 5 mg intramuscular twice a day as needed. This order was discontinued on 1/06/10 at 2:50 PM. The original orders could not be found at the time of the survey. The Medical/ICU Manager, and the hospital's Clinical Educator reviewed the record on 1/07/10 at 2:30 PM, and also could not find the orders. On 1/06/10 at 2:45 PM, the physician ordered Zyprexa 5 to 10 mg by mouth three times a day as needed. This was documented on a physician's order sheet. On 1/06/10 at 2:55 PM, the physician ordered	A 166	This is an addendum to the previous correction submission sent on 2/16/10. Attached as exhibit 9 is a copy of Madison Memorial Hospital's restraint policy. On pg. 2 there was a statement under Procedure: g) iii which read, "The following are NOT classified as restraints, protective devices, such as half side rails, lap trays, mitts, and protective helmets." It was found that this was an error and on 2/18/10 this line was deleted from the policy. This policy was approved 2/18/2010 and over 75% of patient care staff have been educated on this policy and their responsibilities in this regard. The form of education was through viewing a video, power point of the standards, taking a test and return demonstration of soft restraint application. Particular attention was made to the nursing staff on the necessity of updating the plan of care of any patient in restraints. Attached hereto as exhibit 14 are copies of the orders written for both Zyprexa (0430) and Valium (0515). These orders were in the patient's medical record on the date the surveyors were here. The patient had been discharged and her complete medical record was not on the unit, but in the medical records department when we received the call asking us to find them. We apologize that hospital staff did not retrieve the record from the medical records department along with the orders.	

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		A. BUILDING _____ B. WING	

orders.

On 1/06/10 at 2:46 PM, the physician ordered Zyprexa 5 to 10 mg by mouth three times a day as needed. This was documented on a physician's order sheet.

On 1/06/10 at 2:55 PM, the physician ordered

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	130025	A. BUILDING _____ B. WING _____	01/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON MEMORIAL HOSPITAL	450 EAST MAIN STREET REXBURG, ID 83440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 166	Continued From page 27 Patient #56 was very anxious, combative and un-cooperative. The nurse stated that they walked Patient #56 around the halls at which time Patient #56 was hitting and biting at the nurses. Patient #56 was given Zyprexa 5 mg on 1/06/10 at 2:48 PM (which Patient #56 then threw out), and then was given Valium 5 mg on 1/06/10 at 3:03 PM according to the patient's Medication Administration Record. The RN who worked with Patient #56 on 1/06/10 at 1:10 PM, was interviewed. The medication orders and nursing notes were reviewed. She stated that she did not know that using Zyprexa and Valium to control the patient's behaviors was considered a chemical restraint so she did not update Patient #56's Plan of Care to reflect the use of chemical restraints. This was confirmed through record review. 2. Patient #57's medical record documented an 85 year-old male who was admitted to the hospital on 11/27/09. The ED physician's "Clinical Report," dated 11/27/09, stated the patient's diagnoses included "Changed mental status. Dementia. Rule out cerebrovascular accident." A nursing note, dated 11/27/09 at 5:00 PM, stated Patient #57 became combative and aggressive. A verbal order by the PCP for "Haldol 5 mg IV now" was documented on 11/27/09 at 5:15 PM. A form "Restraint: MANAGEMENT OF A VIOLENT OR SELF-DESTRUCTIVE PATIENT BEHAVIOR Order Form", dated 11/27/09 at 5:45 PM, ordered 5 point restraints (wrists, ankles, belt) and a chemical restraint of Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at	A 166	This is an addendum to the previous correction submission sent on 2/16/10. Over 75% of patient care staff have been educated on this policy and their responsibilities in this regard. The form of education was through viewing a video, power point of the standards, taking a test and return demonstration of soft restraint application. Particular attention was made to the nursing staff regarding the use of drugs as a form of restraint. A list of medications frequently known to be used as a chemical restraint has been identified and a question has been inserted into our nursing documentation to ask if these meds are being used as a restraint. The recently enacted restraint policy has been attached as exhibit 9, which clearly identifies staff responsibilities in this regard.	

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A 166	Continued From page 28 8:10 AM, 12:00 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. An order, dated 11/28/09 but not timed, stated "Haldol 10 mg IM every 4 [hours as needed] Ativan 1 mg IM every 4 [hours as needed]." A physician progress note, dated 11/28/09 at 4:25 PM, stated "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." Patient #57 received the following medications: Haldol 5 mg IV at 5:48 PM on 11/27/09. Haldol 5 mg IM at 6:54 PM on 11/27/09. Haldol 10 mg IM at 5:14 AM on 11/28/09. Haldol 10 mg IM at 11:32 AM on 11/28/09. The use of physical restraints was not documented. The "Patient's Plan of Care", dated 11/28/09, stated Patient #57 was at "High Risk: Violence." The plan contained items such as establishing a behavior contract and setting limits on maladaptive behavior. The POC did not address the use of restraints. This was confirmed by interview with the ICU Nurse Manager/EMR Manager on 1/15/09 at 11:15 AM. Patient #57's POC was not modified to include the use of restraints. The hospital failed to ensure hospital staff had incorporated restraint usage into each patient's	A 166	This is an addendum to the previous correction submission sent on 2/16/10. Attached as exhibit 9 is a copy of Madison Memorial Hospital's restraint policy. On pg. 2 there was a statement under Procedure: g) iii which read, "The following are NOT classified as restraints, protective devices, such as half side rails, lap trays, mitts, and protective helmets." It was found that this was an error and on 2/18/10 this line was deleted from the policy. This policy was approved 2/18/2010 and over 75% of patient care staff have been educated on this policy and their responsibilities in this regard. Particular attention was made to the nursing staff on the necessity of updating the plan of care of any patient in restraints. The form of education was through viewing a video, power point of the standards, taking a test and return demonstration of soft restraint application.	

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A 178	Continued From page 39 The RN who worked with Patient #56 on 1/06/10 starting at 1:10 PM, was interviewed. She stated the only time the physician saw Patient #56 on 1/06/10 was around 5:00 PM. She stated that she did not know that using Zyprexa to control the patient's behaviors was considered a chemical restraint, so therefore she did not think to request a face-to-face evaluation by a qualified person. The hospital failed to ensure patients, who had restraints for the management of violent behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention.	A 178	This is an addendum to the previous correction submission sent on 2/16/10. Over 75% of patient care staff have been educated on the restraint policy and their responsibilities in this regard. The form of education was through viewing a video, power point of the standards, taking a test and return demonstration of soft restraint application. Nursing staff have been in-serviced regarding the use of drugs as a form of restraint. A list of medications frequently known to be used as a chemical restraint has been identified and a question has been inserted into our nursing documentation to ask if these meds are being used as a restraint. The recently enacted restraint policy has been attached as exhibit 9, which clearly identifies staff responsibilities in this regard.	
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on patient record review and staff interview, the hospital failed to track and analyze adverse patient events in 2 of 5 patients (#57 and #58) whose records documented the use of chemical and/or physical restraints. Failure to track and analyze adverse events resulted in missed opportunity for the hospital to evaluate processes of care and implement appropriate performance improvement measures to reduce the risk of future adverse events and improve quality and safety of patient care. Findings include: 1. Patient #58 was a 49 year-old female admitted on 11/18/09 to ICU for hypoxia, altered mental status, and aspiration pneumonia. She was	A 267		

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A 438	Continued From page 46 Ativan. The order did not include the dosages of the Haldol and Ativan. It was signed by the PCP but not dated or timed. The form contained lines for signatures to renew the orders. The orders were renewed on 11/28/09 at 8:10 AM, 12:00 noon, 4:30 PM, and 8:30 PM, based on times written by the nurse. A physician signed all 4 renewals. A physician progress note, dated 11/28/09 at 4:25 PM, stated "Reviewed requirement for chemical & soft restraints as needed-Patient with Alzheimers & had combative episode. Agree with restraints Haldol, Ativan, and soft restraint prn." No documentation was present in the medical record that the patient was physically restrained. A rationale for obtaining and renewing the order for physical restraints but not using them was not documented. The Clinical Coordinator for Intensive Care was interviewed at 11:15 AM on 1/15/10. She stated Patient #57 was treated in the ED following the incident. She stated he was seen by the ED physician. She said Patient #57's examination and treatment in the ED was not documented. She confirmed a note by the House Supervisor was not documented. She also stated the use of restraints was not thoroughly documented. Finally, she said the ED physician had conducted a face to face evaluation of the patient following the use of restraints. This was not documented. The hospital failed to document events surrounding the incident and the use of restraints.	A 438	This is an addendum to the previous correction submission sent on 2/16/10. Attached as exhibit 9 is a copy of Madison Memorial Hospital's restraint policy. On pg. 2 there was a statement under Procedure: g) iii which read, "The following are NOT classified as restraints, protective devices, such as half side rails, lap trays, mitts, and protective helmets." It was found that this was an error and on 2/18/10 this line was deleted from the policy. This policy was approved 2/18/2010 and over 75% of patient care staff have been educated on this policy and their responsibilities in this regard. The form of education was through viewing a video, power point of the standards, taking a test and return demonstration of soft restraint application. The "use of restraints" has been added as a QI indicator, which will be monitored for at least the next 6 months by the Performance Improvement Director.	
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service	A 450		

MADISON
MEMORIAL HOSPITAL

Nolan J. Bybee, Performance Improvement Director

450 E. Main Rexburg, ID 83440-0310 (208) 359-6488

February 23, 2010

Bureau of Facility Standards
Patrick Hendrickson, RN, Health Facilities Surveyor
3232 Elder St.
Boise, ID 83720-0036

Dear Mr. Hendrickson:

This is an amendment to the Statement of Deficiency/Plan of Correction submitted February 19, 2010 concerning Medicare CoP A-115, A-144, A-166, A-178, and A-438 in relationship to restraints. Our plan was to have at least 75% of clinical and housekeeping staff trained on the use of restraints. Currently we have 40 nurses (FMC= 22, SST=2, Surgery= 5, House Supervisor= 2, ED= 7, Med/Surg/ICU= 2), who have not completed this training. We have identified who these individuals are and will ensure that they are not assigned to take care of patients who have been placed in restraints until the training has been completed. We have scheduled another restraint training to get 100% compliant with training for our nursing staff for February 24, 2010.

Sincerely,

Nolan J. Bybee, RRT, MBA
Performance Improvement Director
nolan.bybee@mmhnet.org